Welcome to Frostwood Chiropractic

Patient Information

Date _____

Patient Name _____

SSN _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age ____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation _____

Employer/School _____

Spouse/Parent Name _____

SSN _____ Birthdate _____

Spouse/Parent Employer _____

Referral Source
☐ Friend/Family ☐ Insurance ☐ Website ☐ Internet
☐ Yellow Pages ☐ Other _____

Whom may we thank for referring you? _____

Insurance

Policy Holder's Name _____

Relationship to Patient _____

Birthdate _____ SSN _____

Insurance Co. _____

Do you have Medicare? ☐ Yes ☐ No

Is patient covered by additional insurance? ☐ Yes ☐ No

AUTHORIZATION, ASSIGNMENT & RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Frostwood Chiropractic P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Frostwood Chiropractic P.A. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

IN CASE OF EMERGENCY (individual you do NOT live with)

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney/Adjuster Name (if applicable)

_____

Attorney/Adjuster Phone (____) _____

Patient Condition

Reason for Visit _____

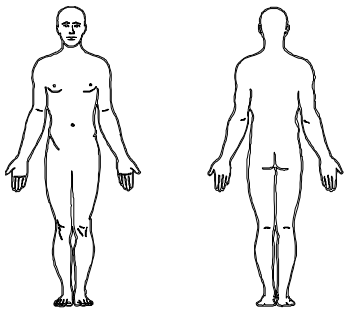
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None

☐ Other _____

Name and Phone # of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal Exam _____ Blood Test _____

Spinal X-Ray _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan _____ Other _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

If so, describe _____

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable

Do you wear ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch Supports

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Please check if you have **ever** had any of the following:

☐ AIDS/HIV	☐ Cataracts	☐ Hernia	☐ Mumps	☐ Scarlet Fever
☐ Alcoholism	☐ Chicken Pox	☐ Herniated Disc	☐ Osteoporosis	☐ Stroke
☐ Allergy Shots	☐ Diabetes	☐ Herpes	☐ Pacemaker	☐ Suicide Attempt
☐ Anemia	☐ Diphtheria	☐ High Cholesterol	☐ Parkinson's	☐ Thyroid Problem
☐ Anorexia	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Tonsilitis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Pinched Nerve	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Pneumonia	☐ Tumor
☐ Asthma	☐ Fever Blisters	☐ Malaria	☐ Polio	☐ Typhoid Fever
☐ Breast Lump	☐ Glaucoma	☐ Measles	☐ Prostate Problem	☐ Ulcers
☐ Bronchitis	☐ Gonorrhea	☐ Migraine	☐ Prosthesis	☐ Vaginal Infection
☐ Bulimia	☐ Gout	☐ Miscarriage	☐ Psychiatric Care	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Chorea	☐ Hepatitis	☐ Multiple Sclerosis	☐ Rheumatoid	☐ Other _____

Medications	Allergies	Vitamins/Herbs/Supplements

Review of Systems

Please check if you currently experience or have experienced any of the following symptoms within the past 6 months. Please check NONE if you have not.

GENERAL
☐ *NONE*
- ☐ Chills
- ☐ Convulsions
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Sweats
- ☐ Weight Loss
- ☐ Weight Gain

MUSCLE & JOINT
☐ *NONE*
- ☐ Arthritis
- ☐ Bursitis
- ☐ Low Back Pain
- ☐ Neck Pain/Stiffness
- ☐ Pain between Shoulder Blades

Pain or Numbness in:
- ☐ Shoulder
- ☐ Arm
- ☐ Elbow
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

- ☐ Painful tail bone
- ☐ Poor Posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen Joints

GASTROINTESTINAL
☐ *NONE*
- ☐ Belching or Gas
- ☐ Colitis
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Gall Bladder problems
- ☐ Hemorrhoids
- ☐ Intestinal Worms
- ☐ Jaundice
- ☐ Liver problems
- ☐ Nausea
- ☐ Pain over Stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting Blood

RESPIRATORY
☐ *NONE*
- ☐ Chronic cough
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Wheezing

NEUROLOGICAL
☐ *NONE*
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Loss of balance
- ☐ Migraines
- ☐ Stroke
- ☐ Tremors

EARS, NOSE & THROAT
☐ *NONE*
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear Noises / Tinnitus
- ☐ Enlarged Glands
- ☐ Enlarged Thyroid
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Tonsillitis

SKIN
☐ *NONE*
- ☐ Boils
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash

CARDIOVASCULAR
☐ *NONE*
- ☐ Chest Pain
- ☐ Hardening of Arteries
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Poor circulation
- ☐ Rapid Heart Beat
- ☐ Slow Heart Beat
- ☐ Swelling in Ankles

EYES
☐ *NONE*
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Failing Vision

PSYCHIATRIC
☐ *NONE*
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Panic Attacks
- ☐ Alcohol/Drug Dependence

GENITOURINARY
☐ *NONE*
- ☐ Bed wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Pus in Urine

WOMEN ONLY
☐ *NONE*
- ☐ Congested Breasts
- ☐ Cramps or backache
- ☐ Excessive Menstrual Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal symptoms
- ☐ Painful Menstruation
- ☐ Vaginal Discharge

Please describe/explain any treatment you have had or are currently receiving for the symptoms checked above. Please also note any other health problems you have that may not have been covered on this form.

_____

_____

_____

_____

Thank You!

Office Policy

We consider all charges to be reasonable and customary for this geographical area. Payment is due in full at the time services are rendered. For your convenience we accept cash, check and credit cards (MasterCard, Visa, American Express and Discover). There is a $30.00 charge on all Returned Checks and we do not accept post-dated checks.

This office may make payment plan arrangement on an individual basis. Any Such plan or arrangement will be discussed during your report of findings.

I understand that neither Frostwood Chiropractic Clinic nor Dr. Mark Hendry participate in any health insurance plans and have opted out of those provider networks.

I understand that if I have an insurance carrier, I am required to sign a private contract detailing the opt out information and that it is my responsibility to contact my health insurance company to determine if I have out-of-network benefits and what those benefits entail.

Minors (Children under the age of 18) should be accompanied by a parent/guardian, however if the parent/guardian is not available, a Consent to Treat form must be sent with the Minor giving the physicians permission to treat your child. The accompanying parent or guardian must assume financial responsibility

We request that you provide us with no less than a 24-hour notice when cancelling or rescheduling a standard office visit. If your appointment is not cancelled within 24-hours of the appointment time and you are unable to make it in for the scheduled time or fail to arrive to your appointment on time and, consequently, the Doctor is unable to see you, this will be considered a missed appointment and is subject to the corresponding fee of $25.

By signing below, I acknowledge that I have read and understand the policy as outlined above.

Patient Signature: _____ Date: _____

Name and Relationship to Patient (If not self): _____

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of examinations, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand an am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. Theses treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Chiropractor Name: Mark T. Hendry, D.C._____

Patient Signature: _____ Date: _____

(Or Patient Parent/Guardian/Representative
Provide Name and Relationship to Patient (If not self): _____

Consent to Use or Disclose Health Information

I, authorize Frostwood Chiropractic Clinic, to use & disclose my medical information for the purposes of Treatment, Payment & Health Care Operations:

*Treatment includes, activities performed by a health care provider, nurse, office staff & other type of health care professionals providing care to you, coordination or managing your care with parties, & consultation with & between other health care providers.

* Payment includes activities involved in determining your eligibility for health plan coverage, billing & receiving payment for your health benefit claims & utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification & pre-authorization.

* Health care operations include the necessary administrative & business functions of our office.
You may review Frostwood Chiropractic Clinic's "Notice of Privacy Practices" for additional information about the uses & disclosures of information described in this consent prior to signing. If you do not wish to receive a copy of our Privacy Notice, please initial: _____

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the notice will be posted in our office. We will offer you a copy of the notice on your first visit to us.

You have the right to revoke this consent, in writing, at any time; however, your decision to revoke the authorization will not affect or undo any use or disclosed information that occurred before your notification.

_____ _____
Signature of Patient Date

_____ _____
Authorized Facility Signature Date

Use of Pre-Authorized Charge Form

I authorize Frostwood Chiropractic P.A. to keep my signature on file and to charge my Credit Card listed below for:

☐ Balance of charges not paid by insurance/patient within 90 days and not to exceed $ _____ for (indicate one): this visit only all visits this year

☐ Recurring charges of $ _____ every _____ from _____ to _____.
(frequency) -(date)-

☐ The one time amount of **$25/$50 (depending on the appointment type) in the event that patient fails to cancel their scheduled appointment 24 hours prior.**

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer Name:_____

Cardholder Name:_____

Card Type: ☐ **V**isa ☐ **M**asterCard ☐ **D**iscover ☐ **A**merican Express

Account Number:_____

Expiration Date:_____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

This form is a pre-authorization to charge credit card payments to your customers. You must still complete the actual credit card charges, including getting an authorization for each transaction.
The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1. The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.
2. The cardholder must choose one of the three payment schedules indicated by each of the three boxes:
   i) Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
   ii) Recurring charges of a specific amount, to be charged on a scheduled basis between two designated dates.
   iii) A total fee, of a designated amount to be charged to the customer's card one time.
3. Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's card expiration date does not extend beyond the "ending date" for any recurring charges.
4. The cardholder must sign and date the form at the bottom.
5. The cardholder receives the top copy, and the bottom two copies are retained by the service provider. (If there is any discrepancy regarding the charges, the provider has the second copy to supply to the cardholder's bank.)
6. The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.