

**CONFIDENTIAL
HEALTH INFORMATION**

Eddy Chiropractic Clinic Inc.
443 Highland Ave
Williamstown, WV 26187
304-375-6000

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced

Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Preferred method of contact?

Home Phone Cell Phone

Work Phone Email

Address

State/Zip

Phone

PRIMARY INSURANCE INFO

Insured's Last Name

Birth Date (MM/DD/YY)

Insured's Social Security #

Insured's First Name

Middle Name (or Initial)

Who carries this policy?

Self Spouse Parent

SECONDARY INSURANCE INFO

Insured's Employer

Employer's Phone

Insured's Last Name

First Name

Middle Initial

Birth Date

Social Security #

Address

City

State/Province

ZIP/Postal Code

Relationship to patient

CONFIDENTIAL HEALTH INFORMATION

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1. The symptom(s) that have prompted me to seek care today include: _____

ADDITIONAL INFO

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

Height: _____

Weight: _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity (How extreme are your current symptoms?) _____

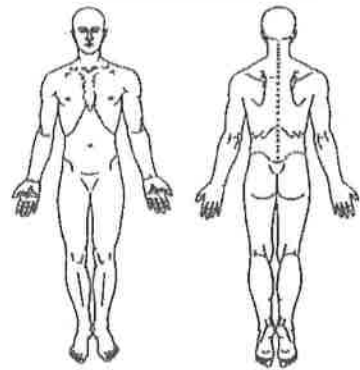
5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____



6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burring
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?) Circle the area(s) on the illustration. "O" for current condition "X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Eddy Chiropractic Clinic know about your current condition? _____

12. How does your current condition interfere with your:

- Work or career: _____
- Recreational activities: _____
- Household responsibilities: _____
- Personal relationships: _____

13. Review of Systems
 Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right. Are you currently treating with a Primary Care Physician Y N

a. Musculoskeletal		b. Neurological		c. Cardiovascular		d. Respiratory		e. Digestive		f. Sensory		g. Skin	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Eddy Chiropractic Clinic Inc.

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

***CONSENT TO TREAT A MINOR CHILD**

Initials _____ I hereby authorize the doctors and assistants at EDDY CHOROPRACTIC, Inc. to administer care as deemed necessary to my (son / daughter) _____

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YY) _____

CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION

By signing this form, you are granting consent to Eddy Chiropractic Clinic Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices (NPP) provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (304) 375.6000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time, it is necessary for representatives of Eddy Chiropractic Clinic Inc. to leave messages for patients. The purposes of these messages are to notify the patient that the doctor would like to discuss results, or to ask a patient to call Eddy Chiropractic Clinic, INC regarding an issue or concern, or to cancel/reschedule an appointment. At no time will a representative of Eddy Chiropractic Clinic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Preferred phone number to be contacted: (_____) _____

_____ approval to leave a message with detailed information

_____ leave a message with call back number ONLY

Signature

Date

Patient Name (Please Print)

.....
HIPAA FORM

If you would like the option of being able to have your spouse, parent, or other individual to discuss your account with us please fill in the form below and sign. If our office does not have signed permission by you, we will be unable to honor any request for information from any of these parties. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Names authorized on account (list relationship), if no one is authorized, write N/A below, mark No Consent.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

<input type="checkbox"/> Medical only
<input type="checkbox"/> Financial only
<input type="checkbox"/> All
<input type="checkbox"/> No Consent

Patient Signature

Date

Patient Name (print please)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Patient Date of Birth: _____

SS Number: _____

I authorize the use and disclosure of the above individual's health information as described below.

The following individual or organization is authorized to make the PHI disclosure.

Physician/Facility

Address

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- | | | |
|---|----------------------------------|---|
| <input type="checkbox"/> All medical records | from (date _____ to (date) _____ | <input type="checkbox"/> All dates of service |
| <input type="checkbox"/> Most recent history and physical | | |
| <input type="checkbox"/> Most recent discharge summary | | |
| <input type="checkbox"/> Office visits | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Laboratory results | from (date _____ to (date) _____ | |
| <input type="checkbox"/> X-ray and imaging reports | from (date _____ to (date) _____ | |
| <input type="checkbox"/> X-ray and imaging disc | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Consultation reports | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Other _____ | | |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and/or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual organizations:

Eddy Chiropractic Clinic Inc.
443 Highland Avenue, Williamstown, WV 26187
Phone: (304) 375.6000 Fax: (304)375.6043

The use or disclosure for which this request is made is: Review of medical records for diagnosis and/or treatment.

I understand that I may revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Eddy Chiropractic Clinic. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***This authorization will expire one year from the date signed.***

I understand that authorizing the disclosure of this individually identifiable health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal privacy regulations.

I hereby authorize the use or disclosure of my PHI as described below.

Signature of patient or patient's legal representative (Form MUST be completed before signing.)

Date

Printed name of patient's representative: _____

Relationship to the patient: _____



EDDY CHIROPRACTIC CLINIC, INC.

Exercise Wellness Center

Dr. Steven L. Eddy

443 Highland Ave., Williamstown, WV 26187 • (304) 375-6000 • Fax (304) 375-6043

GOOD FAITH ESTIMATE & FINANCIAL RESPONSIBILITY WAIVER

In this office, our major concern is to assist you in maintaining overall good health. As a patient with insurance coverage, you should be aware that insurance policies can vary greatly in terms of coverage, limitations, covered services and referral requirements. **We strongly recommend that each patient contact his/her own insurance company to verify their individual coverages.** Per our contract with your insurance carrier, it is required that you, the patient, be personally responsible for the payment of your deductibles/copays/co-insurance and charges that may exceed your coverage, prior to receiving treatment.

If at any time you fail to present our office with your current insurance card(s), fail to secure any necessary referral to be seen in our office, do not have current authorization on record for treatment in our office, exceed visit limitations, or receive non-covered services, the charges incurred will become your responsibility.

Please refer to the list below for the pricing of common services offered in our office so that you are aware of what charges will apply in the event you are responsible. This is not a complete list of services/supplies, pricing can be obtained from any of our staff should you have further concerns.

SERVICES		STANDARD CHARGES (Insurance)	CHUSA DISCOUNT (\$49 enrollment fee)	PATIENT OPTIONS (no enrollment fee - 1/1/22)
Examinations	99202/99212	\$90.00/\$80.00	\$75.00/\$65.00	\$75.00/\$65.00
Detailed Examinations	99203/99213	\$140.00/\$115.00	(Worker's Compensation & Personal Injuries)	
X-rays	Multiple codes	\$110.00 and up	\$30.00 per view taken	\$30.00 per view taken
Spinal Manipulation	98940/98941/98942	\$50.00/\$60.00/\$70.00	\$40.00	\$40.00
Electrical Stim.	97014	\$35.00	\$20.00	\$20.00
Ultrasound	97035	\$35.00	\$20.00	\$20.00
Cold Laser	97039	\$35.00	\$20.00	\$20.00
Extremity Manipulation	98943	\$50.00	\$35.00	\$35.00

Charges may vary based on your diagnosis determined upon your visit. Our staff will be happy to assist you with any questions you may have about your insurance benefits.

I have read and agree to receive the care recommended and accept financial responsibility for services provided.

Patient Signature

Date

Witness Signature

Date



EDDY CHIROPRACTIC CLINIC, INC.

Exercise Wellness Center

Dr. Steven L. Eddy

443 Highland Ave., Williamstown, WV 26187 • (304) 375-6000 • Fax (304) 375-6043

PATIENT OPTIONS ACCESS PROGRAM FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is **NO FEE** for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

- The Program provides discounts to you from contracted healthcare providers for services rendered;
- The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options;
- **This is NOT insurance** or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third party insurance company is responsible for charges.
- Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;
- The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options. I have read and agree to the terms and conditions set forth above:

Signature: _____ Printed Name: _____ Date: ____/____/____

Address: _____

Patient Election to Self-Pay

This office may participate in my personal health insurance plan, if any, and I understand certain health plans may require submission of claims for consideration of payment. I understand my health plan, if any, may include benefits for some or all of the services that are proposed by this office.

I also hereby elect to self-pay for services rendered to me at this office. By electing to self-pay for certain designated services, any payments made to this office will not be billed to my health plan, if any, and/or credited towards any deductible or coinsurance obligation under my health plan unless allowed by that plan.

Unless requested in writing, I hereby direct this office to not submit claims for specific services in which I elect to self-pay. Such information may include but not be limited to my diagnosis, history, payments, office notes and/or other documentation necessary for traditional third-party insurance payment.

I understand I am fully responsible for services accrued at this office. I acknowledge I may qualify for other discounts offered through this office, including but not limited to a Patient Options discount medical plan organization membership fee schedule on file with this office.

Signature: _____ Printed Name: _____ Date: ____/____/____

Eddy Chiropractic Clinic Inc.
443 Highland Avenue
Williamstown, WV 26187
304-375-6000

To Our Medicare Patients:

Patients with Medicare Part B coverage do have chiropractic benefits on their policy. Medicare allows payment for spinal manipulation only by a doctor of chiropractic when it is determined by Medicare to be a covered expense. When Medicare processes claims, they determine whether services furnished are covered expenses under Medicare, whether the patient's deductible has been met, and whether services furnished are reasonable and necessary.

In order for Medicare to determine that services are medically necessary a misalignment (subluxation) must be present in your spine. The best way to determine if a subluxation is present is by a thorough physical examination and x-ray examination. However, Medicare does not cover these examination and x-ray services. Charges for these exams will become the patient's responsibility and when applicable will be billed to any supplemental policies the patient may also carry.

1. Do you or your spouse work for a company that provides you with health insurance? Yes ___ No ___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes ___ No ___
3. Is this illness or injury the result of an accident or other injury? Yes ___ No ___
4. Is this illness or injury the result of an accident or illness that occurred at work? Yes ___ No ___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes ___ No ___
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes ___ No ___
7. Do you have a Medicare Medigap Policy? Yes ___ No ___
8. Do you have a Medicare Supplement Policy? (policy provided by employer you retired from)? Yes ___ No ___

Patient Signature

Date

Witness

Date