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

Address

State/Zip

Phone

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

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: ____________________

____

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 ____________________

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

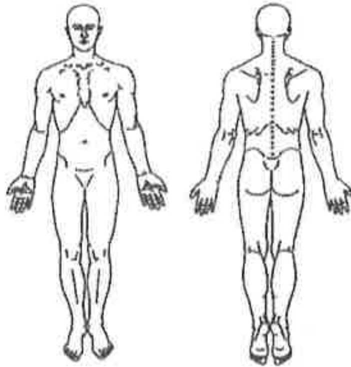
4. Intensity (How extreme are your current symptoms?)
0 ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ 10

Absent Uncomfortable Agonizing

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
- ◯ Burning
- ◯ 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**
Name of Physician: ____________________

a. Musculoskeletal (Had / Have)
◯ ◯ Osteoporosis ◯ ◯ Arthritis ◯ ◯ Scoliosis ◯ ◯ Neck pain ◯ ◯ Back problems ◯ ◯ Hip disorders — NONE ◯
◯ ◯ Knee injuries ◯ ◯ Foot/ankle pain ◯ ◯ Shoulder problems ◯ ◯ Elbow/wrist pain ◯ ◯ TMJ issues ◯ ◯ Poor posture — Initials ____

b. Neurological (Had / Have)
◯ ◯ Anxiety ◯ ◯ Depression ◯ ◯ Headache ◯ ◯ Dizziness ◯ ◯ Pins and needles ◯ ◯ Numbness — NONE ◯ Initials ____

c. Cardiovascular (Had / Have)
◯ ◯ High blood pressure ◯ ◯ Low blood pressure ◯ ◯ High cholesterol ◯ ◯ Poor circulation ◯ ◯ Angina ◯ ◯ Excessive bruising — NONE ◯ Initials ____

d. Respiratory (Had / Have)
◯ ◯ Asthma ◯ ◯ Apnea ◯ ◯ Emphysema ◯ ◯ Hay fever ◯ ◯ Shortness of breath ◯ ◯ Pneumonia — NONE ◯ Initials ____

e. Digestive (Had / Have)
◯ ◯ Anorexia/bulimia ◯ ◯ Ulcer ◯ ◯ Food sensitivities ◯ ◯ Heartburn ◯ ◯ Constipation ◯ ◯ Diarrhea — NONE ◯ Initials ____

f. Sensory (Had / Have)
◯ ◯ Blurred vision ◯ ◯ Ringing in ears ◯ ◯ Hearing loss ◯ ◯ Chronic ear infection ◯ ◯ Loss of smell ◯ ◯ Loss of taste — NONE ◯ Initials ____

g. Skin (Had / Have)
◯ ◯ Skin cancer ◯ ◯ Psoriasis ◯ ◯ Eczema ◯ ◯ Acne ◯ ◯ Hair loss ◯ ◯ Rash — NONE ◯ Initials ____

ADDITIONAL INFO
Height: ______
Weight: ______

Eddy Chiropractic Clinic Inc.

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(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ___

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction		○	PMS symptoms	NONE ○ Initials ___

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	NONE ○ Initials ___

Please list all Medications

______
______
______
______
______
______
______
______
______
______
______

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ______
○	○	Cancer			______
○	○	Chicken pox			______
○	○	Diabetes			______
○	○	Epilepsy			______
○	○	Glaucoma			______
○	○	Goiter			______
○	○	Gout			______
○	○	Heart disease			______
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

○ Appendix removal
○ Bypass surgery
○ Cancer
○ Cosmetic surgery
○ Elective surgery: ______
______
○ Eye surgery
○ Hysterectomy
○ Pacemaker
○ Spine ______
______
______
○ Tonsillectomy
○ Vasectomy
○ Other: ______
______
______
______

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ______
______
______

○	○	Medications (prescription and over-the-counter):

______
______
______

17. Injuries

Have you ever...

○	Had a fractured or broken bone	○	Used a crutch or other support
○	Had a spine or nerve disorder	○	Used neck or back bracing
○	Been knocked unconscious	○	Received a tattoo
○	Been injured in an accident	○	Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Eddy Chiropractic Clinic about the health of your immediate family members.

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	______	○	○	______	______	○	○
Father	______	○	○	______	______	○	○
Sister 1	______	○	○	______	______	○	○
Sister 2	______	○	○	______	______	○	○
Brother 1	______	○	○	______	______	○	○
Brother 2	______	○	○	______	______	○	○
______	______	○	○	______	______	○	○

19. Are there any other hereditary health issues that you know about? ______

______

SOCIAL

20. Social History

Tell Eddy Chiropractic Clinic about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? ______
Coffee use	○ Daily	○ Weekly	How much? ______
Tobacco use	○ Daily	○ Weekly	How much? ______
Exercising	○ Daily	○ Weekly	How much? ______
Pain relievers	○ Daily	○ Weekly	How much? ______
Soft drinks	○ Daily	○ Weekly	How much? ______
Water intake	○ Daily	○ Weekly	How much? ______
Hobbies: ______			

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Eddy Chiropractic Clinic Inc.

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21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

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

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 hearby authorize the doctors and assistants at EDDY CHOROPRACTIC, Inc. to administer care as deemed nessessary to my (son / daughter) ____________.

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

Signature ____________ **Date (MM/DD/YY)** ____________

Eddy Chiropractic Clinic Inc.

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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: ______________

___ Medical only
___ Financial only
___ All
___ 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):

__ All medical records from (date ____________ to (date) ____________ ☐ All dates of service
__ Most recent history and physical
__ Most recent discharge summary
__ Office visits from (date ____________ to (date) ____________
__ Laboratory results from (date ____________ to (date) ____________
__ X-ray and imaging reports from (date ____________ to (date) ____________
__ X-ray and imaging disc from (date ____________ to (date) ____________
__ Consultation reports from (date ____________ to (date) ____________
__ 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:____/____/____