

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

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Insured's Social Security Number

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

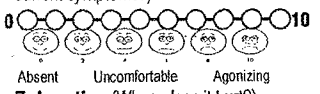
PAGE 1/4

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

Patient name _____

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 _____

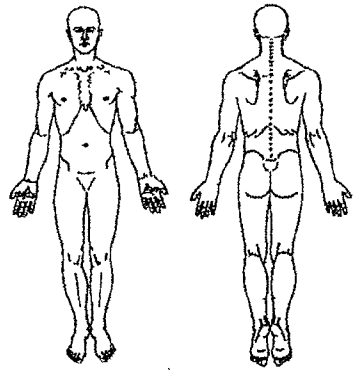
3. Onset (When did you first notice your current symptoms?)

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.
 "0" 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.

	Currently treating with Primary Care Physician		Y		N		Name of Physician					
a. Musculoskeletal												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	Initials _____
b. Neurological												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	Initials _____
c. Cardiovascular												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	Initials _____
d. Respiratory												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	Initials _____
e. Digestive												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	Initials _____
f. Sensory												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	Initials _____
g. Skin												
Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	Had <input type="radio"/> Have <input type="radio"/>	NONE <input type="radio"/>			
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	Initials _____

Consultation Notes

Doctor's Initials _____
 Eddy Chiropractic Clinic Inc.

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

j. Constitutional

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

Patient name _____

All other systems negative

Past Personal, Family and Social History

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

14. Illnesses

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

- | | | | | | |
|---------------------------|----------------------------|------------------------------|---------------------------|----------------------------|---------------|
| Had <input type="radio"/> | Have <input type="radio"/> | AIDS | Had <input type="radio"/> | Have <input type="radio"/> | Tuberculosis |
| <input type="radio"/> | <input type="radio"/> | Alcoholism | <input type="radio"/> | <input type="radio"/> | Typhoid fever |
| <input type="radio"/> | <input type="radio"/> | Allergies | <input type="radio"/> | <input type="radio"/> | Ulcer |
| <input type="radio"/> | <input type="radio"/> | Arteriosclerosis | <input type="radio"/> | <input type="radio"/> | Other: _____ |
| <input type="radio"/> | <input type="radio"/> | Cancer | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Chicken pox | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Diabetes | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Epilepsy | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Glaucoma | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Goiter | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Gout | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Heart disease | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Hepatitis | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | HIV Positive | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Malaria | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Measles | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Multiple Sclerosis | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Mumps | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Polio | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Rheumatic fever | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Scarlet fever | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Sexually transmitted disease | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | 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 <input type="radio"/> | Currently <input type="radio"/> | Acupuncture |
| <input type="radio"/> | <input type="radio"/> | Antibiotics |
| <input type="radio"/> | <input type="radio"/> | Birth control pills |
| <input type="radio"/> | <input type="radio"/> | Blood transfusions |
| <input type="radio"/> | <input type="radio"/> | Chemotherapy |
| <input type="radio"/> | <input type="radio"/> | Chiropractic care |
| <input type="radio"/> | <input type="radio"/> | Dialysis |
| <input type="radio"/> | <input type="radio"/> | Herbs |
| <input type="radio"/> | <input type="radio"/> | Homeopathy |
| <input type="radio"/> | <input type="radio"/> | Hormone replacement |
| <input type="radio"/> | <input type="radio"/> | Inhaler |
| <input type="radio"/> | <input type="radio"/> | Massage therapy |
| <input type="radio"/> | <input type="radio"/> | Physical therapy |
| <input type="radio"/> | <input type="radio"/> | Nutritional supplements: |
- List: _____

17. Injuries

Have you ever...

- | | |
|--|--|
| <input type="radio"/> Had a fractured or broken bone | <input type="radio"/> Used a crutch or other support |
| <input type="radio"/> Had a spine or nerve disorder | <input type="radio"/> Used neck or back bracing |
| <input type="radio"/> Been knocked unconscious | <input type="radio"/> Received a tattoo |
| <input type="radio"/> Been injured in an accident | <input type="radio"/> Had a body piercing |

PERSONAL

Consultation Notes

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		Illnesses	Age at death	Cause of death	
		Good <input type="radio"/>	Poor <input type="radio"/>			Natural <input type="radio"/>	Illness <input type="radio"/>
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

20. Social History

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

- | | | | | |
|----------------|--|-----------------|-----------------------|--|
| Alcohol use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? | <input type="radio"/> Yes <input type="radio"/> No |
| Coffee use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress? | <input type="radio"/> Yes <input type="radio"/> No |
| Tobacco use | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace? | <input type="radio"/> Yes <input type="radio"/> No |
| Exercising | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated? | <input type="radio"/> Yes <input type="radio"/> No |
| Pain relievers | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings? | <input type="radio"/> Yes <input type="radio"/> No |
| Soft drinks | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs? | <input type="radio"/> Yes <input type="radio"/> No |
| Water intake | <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | | |
| Hobbies: | _____ | | | |

SOCIAL

Doctor's Initials _____

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"/>

Patient name _____

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 Chiropractic Clinic, Inc. to administer chiropractic care as deemed necessary to my (son / daughter) _____.

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

Consultation Notes

Doctor's Initials _____

Eddy Chiropractic Clinic Inc.

Signature _____

Date (MM/DD/YYYY) _____

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 2022

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, please write N/A below.

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.

Person/Organization

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	\$75.00/\$65.00	\$60.00/\$40.00	\$60.00/\$40.00
Detailed Examinations	99203/99213	\$125.00/\$100.00	(Worker's Compensation & Personal Injuries)	
X-rays	Multiple codes	\$75.00 and up	\$20.00 per view taken	\$20.00 per view taken
Spinal Manipulation	98940/98941/98942	\$40.00/\$50.00/\$60.00	\$30.00	\$30.00
Electrical Stim.	97014	\$25.00	\$15.00	\$15.00
Ultrasound	97035	\$25.00	\$15.00	\$15.00
Cold Laser	97039	\$25.00	\$15.00	\$15.00
Extremity Manipulation	98943	\$30.00	\$25.00	\$25.00

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

West Virginia Workers' Compensation Employees' and Physicians' Report of Occupational Injury or Disease

PLEASE PRINT OR TYPE

Section I	Employee's Claim Information
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Insurer:		Third-Party Administrator:	
1. Name: (Last): _____ (First): _____ (M.I.): _____		3. Telephone: () - -	
2. Address: City: _____ State: _____ Zip: _____		4. Social Security No.: - - -	
5. Date of Birth: ____/____/____	6. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status:	
8. Date of Injury or Last Exposure: ____/____/____ Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		9. Time You Began Work on Date of Injury: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
10. Date You Stopped Working Due to Injury: ____/____/____			
11. Have You Retired? <input type="checkbox"/> yes <input type="checkbox"/> no		If "yes," what was the date you retired: ____/____/____	
12. Employer's Name: Address: City: _____ State: _____ Zip: _____ Telephone: () - -		Supervisor's Name:	
13. Job Title/Description:			
14. Body Part(s) Injured:			
15. Describe How Your Injury Occurred (Specify the cause, what you were doing, and equipment/objects involved):			
16. Did Injury Occur on Employer's Property? <input type="checkbox"/> Yes <input type="checkbox"/> No Address where injury occurred:			
17. Please Identify Any Witnesses to Your Injury:			
<p>I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.</p>			
Employee's Signature: _____		Date: ____/____/____	

Section II	All Information Must Be Completed by Initial Healthcare Provider
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1. Name of Physician/Hospital:		2. FEIN/Social Security No.: - - -	
3. Address: City: _____ State: _____ Zip: _____ Telephone: () - -			
4. Date of Initial Treatment: ____/____/____		5. Date Patient May Return to Work: ____/____/____	
6. Have you advised the patient to remain off work 4 or more days? <input type="checkbox"/> Yes. Indicate dates: from _____ to _____ <input type="checkbox"/> No. If "no," is the patient capable of <input type="checkbox"/> Full Duty <input type="checkbox"/> Modified Duty If the patient is capable of returning to modified duty, specify any limitations/restrictions:			
7. Condition is a direct result of: <input type="checkbox"/> Occupational Injury? <input type="checkbox"/> Occupational Disease? <input type="checkbox"/> Non-Occupational Condition?			
8. Did this injury aggravate a prior injury/disease? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, explain:			
9. Description of injury or occupational disease:			
10. Body part(s) injured:		11. ICD-10-CM Diagnosis Code(s) in order of severity:	
12. Name of physician referred to:		13. If the patient was hospitalized, where?	
<p>I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.</p>			
Signature: _____		Date: ____/____/____	

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec. # _____
Address _____
Street City State Zip
Home Phone (_____) _____ E-mail _____
Cell Phone (_____) _____ Occupation _____

EMPLOYER

Employer Name _____
Employer Address _____
Street City State Zip
Employer Phone (_____) _____ Injury Verified by (For Office Use) _____
Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____
Carrier Address _____
Street City State Zip
Carrier Phone (_____) _____ Coverage Verified by _____
Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ AM PM Place of Injury _____
Accident reported to employer? Yes No Name of person you reported accident to _____
Give full description of how accident happened _____

Have you lost time from work? Yes No How much? _____
Other doctors seen for this condition: Doctor's Name _____
Diagnosis _____ Were X-Rays taken? Yes No Other Tests? Yes No
If yes, by whom? Please list test(s) and result(s) _____

Any previous Worker Compensation injuries? Yes No Date(s) of previous injuries _____
Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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

Relationship to Patient



Request for Change / Opt-Out

Return completed form to:
BrickStreet Mutual Insurance
P. O. Box 3151
Charleston, WV 25332-3151

Change of Physician

Opt-Out of Provider Network

1. Claimant's Name:	
2. Claim Number:	
3. Social Security Number:	
4. Date of Injury:	

I am requesting to: <input type="checkbox"/> Change physicians to another network provider <input type="checkbox"/> Seek treatment with an out-of-network physician	
I am presently being treated by:	
I am requesting to change to:	
Address of requested physician (Street, City, State, Zip):	
My reason for changing physicians or seeking treatment out of network:	
I have checked with the requested physician to see if he / she will take me as a patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Claimant's Signature	Date