Celanese Chiropractic Health & Performance
P: (803) 323-5500
F: (803) 323-5501
1924 Mount Gallant Rd.
Rock Hill, SC 29732

PATIENT INFORMATION

Full Name ______________________ Date of Birth ______________ Gender M F

Address ______________________ SS# _____-_____-_____ Work Phone ________________

City __________ State _____ Zip ________ Cell Phone ______________________

In order to receive text reminders, please provide your phone carrier (AT&T, Verizon, Sprint, etc.)____________

Email ______________________________ Referred by ________________________

Marital Status S M W D Sep. / Spouse Name ________________ Date of Birth ______________

Are you a student Y N / Full-time Part-time

Your Employer __________________________ Your Occupation __________________________

Employer Address __________________________ City __________ State ______ Zip ________

Spouse's Employer ______________________ Spouse's Occupation ________________________

Insurance Provider ______________________ Member ID ______________________________

Insurance policy holder's name ______________________ Date of Birth ______________

Current medications ____________________________ Are you or could you be pregnant? ☐ YES ☐NO

Do you exercise? ☐ YES ☐ NO If yes how many times a week? ________________

Family History

	Mother	Father	Siblings
Back Pain			
Neck Pain			
Headaches			
Pinched Nerve			
Scoliosis			
Arthritis			

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the notice of privacy practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature ________________________________ Date ______________

Spouse's or Guardian Signature ____________________________ Date ______________

(Authorization expires three years from date above)

CASE HISTORY

History of Present Injury/ Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1 ______________________________ How long? ______________

2 ______________________________ How long? ______________

3 ______________________________ How long? ______________

4 ______________________________ How long? ______________

What words would best describe your condition(s)? (example: ache, burn)____________________

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? ______________________________

When is your condition least severe? ______________________________

What makes your condition feel worse?______________________________

What makes your condition feel better? ______________________________

What activities are difficult because of your condition(s)? ______________________________

Is your condition(s) related to an accident? ☐ YES NO Date of accident ____________

Type of accident: Auto Work Related Other ______________

Have you seen any other health care provider for your present condition? YES NO Name of provider/facility ____________________

Are you experiencing or do you have any of the following?

A sore that won't heal	Difficulty Swallowing	Persistent cough/hoarseness
Any bleeding/discharge	Lump/thickening anywhere	Wart/ mole changes
Bladder/bowel problems	Night Pain	None of the above

Review of systems

In addition to the symptom(s) / dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

Anxiety	Facial drooping	Memory loss	Sensory changes
Atrophy	Headache	Mood swings	Speech problems
Concussion	Joint deformity	Muscle weakness	Stiffness
Depression	Joint locking	Numbness	Tremors
Difficulty Walking	Lack of coordination	Popping noises	Twitches
Dizziness	Limited range of motion	Psychiatric disorders	Vision trouble
Extremity deformity	Loss of balance	Seizures	**None of the above**

Cardiovascular System

Ankle swelling	Chest pain	Jaw pain	Pin stroke
Blood clots	Dizziness	Known vascular	Previous stroke
Carotid blockage	Fainting	Mitral valve prolapse	Shortness of breath
Changes in skin color	Hypertension	Phlebitis	Varicose veins

Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1.____________________ Date __________ 3.____________________ Date __________

2.____________________ Date __________ 4.____________________ Date __________

Have you ever been hospitalized for anything in addition to surgeries? YES NO

If so, when and for what reason? ______________________________

Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)

YES NO ______________________________

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

YES NO

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FINANCIAL HARDSHIP WAIVER

Patient Name____

Phone____

Address____

City_______________________ State______________ Zip____________

For the reason checked below, I am unable to pay the unreimbursed medical charges due to economic hardship. In addition, I do not have a guardian or other responsible party who can assist me with these expenses. Please explain: (Mark all that apply)

__ Unemployed

__ No Insurance

__ Bankrupt

__ Student

__ Other:____

__ Not Covered by State or Local Welfare Program

__ Dependent on Family for Support

__ High Medical Expenses

__ Low or Fixed Income

Patient Signature__________________________________ Date________________

OFFICE USE ONLY

I waive the collection of unreimbursed medical charges on the above mentioned patient/family:

Authorized Signature______________________________ Date________________

ELECTION TO NOT CLAIM HEALTH INSURANCE

The staff has informed me that if I file on my own health insurance, I will be responsible for paying deductibles and co-payments and that any such payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

I have decided that I do not wish to file any claim on my health insurance. I hereby direct and authorize the clinic to send bills and treatments records only to me, my attorney, the liability insurance carrier, or to my own automobile insurer for the purpose of receiving payment under my Medical Payments, Uninsured or Under-Insured Motorist coverage, if applicable. I am aware that if I have instructed this facility to send any information to my attorney, adjuster, or third party persons that I must first sign a separate and distinct release that is in accordance with HIPAA.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments, however will be billed at the clinic's usual rates rather than at discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date and that I should consider the decision I am making today not to file on my health insurance to be irreversible. I also understand that any penalties that Celanese Chiropractic Health & Performance may incur, as a result of non-timely filing, will be assigned to the patient.

FOR ALL PERSONAL INJURY RELATED CLAIMS

I understand that if for any reason, my liability claim is ultimately denied, compromised or litigated unsuccessfully, I will remain personally liable for the reasonable value of the treatment rendered to me by the clinic and for any difference in settlement payments.

______________________________ ______________

Patient Signature Date

____

Witness

CELANESE CHIROPRACTIC HEALTH & PERFORMANCE

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give consent to release this information to the individuals indicated below. This consent form will not allow Celanese Chiropractic Health & Performance to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Celanese Chiropractic Health & Performance to release my medical and/or billing information to the following individual(s):

1. ________________________________ Relation to Patient:__________________

2. ________________________________ Relation to Patient:__________________

3. ________________________________ Relation to Patient:__________________

Patient Name:____

Patient Signature:____________________________ Date:__________________________

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Celanese Chiropractic Health & Performance to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Celanese Chiropractic Health & Performance discuss your medical 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.

Patient Name:____

Patient Signature:____________________________ Date:__________________________

*For Office Use Only: Patient ID*________________

Cancelation Policy:

We understand that unanticipated events happen occasionally in everyone's life. Due to the high need for massage therapy, please observe the following policies:

24-hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged a cancellation fee for your appointment.

No-shows

No Call within 24 hours or "no show" will be charged a cancellation fee for their "missed" appointment.

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this practice.

______________________________ ____________________

Patient Signature Date

Payment Policies:

- If you have a copay plan, you are expected to pay the full copay amount at the time services are rendered

- If you have a plan where you have to meet a deductible, you are expected to pay ___$55___ per appointment (after your 1st appt.), which goes towards your deductible balance. Once you have met your deductible through your health plan, and your deductible balance is paid off, your cost will drop to your plan's coinsurance amount

- If you are unable to pay at the time of services, you MUST make prior arrangements with the office staff

______________________________ ________________

Patient Signature Date