

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 \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ 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

**Patient Billing Acknowledgement Form  
Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include items such as vitamins or certain chiropractic supplies.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

Non-covered services may include but not limited to:

**Procedures**

**Reason**

Taping

Insurance does not cover

Interferential Current

Mechanical Traction

Ice Compression

Pneumatic Compression Sleeves

Maintenance

Supplements/Supplies

Orthotics

Therapeutic Massage

---

**Patient**

I \_\_\_\_\_, acknowledge that I have been told in advance by my provider  
Name-please print

that the services/products listed above are not covered by my health plan. I agree to pay for these non-covered services.

**SEE BACK...**

**Celanese Chiropractic Health & Performance**  
1924 Mt. Gallant Road  
Rock Hill, SC 29732

At Celanese Chiropractic Health & Performance our major concern is to assist you in maintaining overall good health. However, we feel it is our responsibility to let you know that your insurance is only responsible for those visits necessary to return you to your symptomatic improvement.

Once we have reduced your symptoms your insurance may no longer be responsible for payment of any additional care.

Since often it is beneficial for the patient to continue supportive care, we like to inform you in advance that you may be financially responsible.

I have read and understand the above information:

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**RELEASE AND ASSIGNMENT**

**TO MY INSURANCE CARRIER:**

1. I authorize the release of any information necessary to process my insurance claims.
2. I authorize and request payment of medical benefits directly to my physician named below:

**Celanese Chiropractic Health & Performance**  
1924 Mt. Gallant Road  
Rock Hill, SC 29732

3. I agree this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this document may be used in lieu of the original.

Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

# 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