PATIENT CASE HISTORY

Dear Patient: Thank you for giving us the opportunity to treat your health care needs. The following information is very important in assessing your health problem. Your answers will help us determine if Chiropractic can help you. Rest assured, if we believe your condition will not respond satisfactorily to Chiropractic care, we will not accept you as a patient, but will make referral to the necessary health care provider. Please answer all applicable questions completely. **PLEASE PRINT**. *THANK YOU!*

DATE: _____ PATIENT #: _____

HOW DID YOU HEAR ABOUT US: Medical Doctor / Attorney / Friend / Family / Advertisement

REFFERED BY: _____ PCP: _____

NAME: _____ BIRTHDATE: _____ AGE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ E-MAIL: _____

SOCIAL SECURITY #: _____ SEX: M / F MARITAL STATUS: S M W D

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ # OF CHILDREN: _____ AGES OF CHILDREN: _____

NAME OF INSURANCE COMPANY: _____

PLEASE CIRCLE THE AREA(S) OF YOUR MAJOR COMPLAINTS:

(SPINE): NECK / UPPER BACK / MID BACK / LOWER BACK / HIP

(EXTREMITY): SHOULDER / ELBOW / WRIST / HAND / KNEE / ANKLE / FOOT

IS THIS A RESULT OF A SPECIFIC INCIDENT (EXPLAIN): _____

_____

WHEN DID IT START: _____

HAVE YOU HAD THIS CONDITION BEFORE? YES / NO IF YES, WHEN? _____

WHAT MAKES IT WORSE? _____

WHAT MAKES IT BETTER? _____

IS THE CONDITION GETTING BETTER OR WORSE? BETTER / WORSE

IS YOUR CONDITION CONSTANT OR DOES IT COME & GO? _____

DOES THIS CONDITION INTERFERE WITH: WORK / SLEEP / DAILY ACTIVITIES

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? YES / NO

IF SO, PLEASE LIST THE DOCTOR'S NAME(S) AND LOCATION(S): _____

_____ RESULTS: GOOD / FAIR / POOR

HAVE YOU HAD ANY OTHER TREATMENT FOR THIS CONDITION? YES / NO

WHERE: _____ RESULTS: GOOD / FAIR / POOR

HAVE YOU EVER BEEN IN AN ACCIDENT OR HAD OTHER SERIOUS INJURY? IF YES, PLEASE DESCRIBE, GIVE DATES: _____

HAVE YOU HAD ANY BROKEN BONES OR MAJOR DISCLOCATIONS? IF YES, PLEASE DESCRIBE, GIVE DATES: _____

HAVE YOU EVER HAD SURGERY? IF YES, PLEASE DESCRIBE, GIVE DATES:

_____

HAVE YOU EVER BEEN HOSPITALIZED? IF YES, PLEASE DESCRIBE WHY, GIVE DATES: _____

_____

ARE YOU TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION DRUGS? PLEASE LIST AND EXPLAIN FOR WHAT CONDITION: _____

HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE? Y / N

IF YES, NAME AND LOCATION OF DOCTOR: _____

DATE OF LAST ADJUSTMENT: _____ FAVORABLE RESULTS?: _____

AUTHORIZATION for TREATMENT *and* RELEASE of INFORMATION

I authorize Dr. Brian Moreland and/or Back in Motion Chiropractic, LLC to examine, order x-rays (if necessary), treat me and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Dr. Brian Moreland and/or Back in Motion Chiropractic, LLC will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to be paid directly to Dr. Brian Moreland and/or Back in Motion Chiropractic, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that a monthly service charge of $10.00/month may be applied to any account that does not follow a signed financial arrangement.

I hereby authorize the release of information and treatment records for the purpose of assisting in collections from the insurance company.

Patient's Signature: _____ Date: _____

Guardian/Spouse Signature Authorizing Care: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Dr. Brian Moreland and Back in Motion Chiropractic, LLC's Notice of Privacy Practices for protected health information.

Date: _____

Printed Name of Patient: _____

Signature of Patient/Personal Representative: _____

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of the Notice of Privacy Practices for protected health information of Dr. Brian Moreland and Back in Motion Chiropractic, LLC by:

(*Check all that apply*)

- ❑ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service
- ❑ Showing the patient the Notice of Privacy Practices posted in our office
- ❑ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ❑ Asking the patient to sign this Acknowledgement form
- ❑ Other (explain in detail) _____

_____

I was unable to obtain the patient's written Acknowledgement because:

(*Check all that apply*):

- ❑ The patient refused to sign this form
- ❑ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ❑ Other (explain in detail):_____

_____

Date: _____ Printed Staff Name: _____

Staff Signature: _____

This written Acknowledgement must be completed no later than the first date health care services or treatment are provided to the patient after April 21, 2003, the date the Health Insurance Portability and Accountability Act was enacted. This Acknowledgement must be retained in the patient's permanent records.

BACK IN MOTION CHIROPRACTIC, LLC
INSURANCE ASSIGNMENT PROGRAM

It is our desire to provide whatever financial assistance our patients may require whenever possible to ensure that patients get the care they need. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

Waiting for insurance payment is a courtesy provided by Back In Motion Chiropractic, LLC and Dr. Brian Moreland. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify when this change in status is achieved.

You must pay all deductible amounts as those charges are accrued. Also, you must remain current with your co-insurance (percentage of responsibility) or co-pays.

We participate in many insurance programs. For insurances that do require a single or multiple co-pays, these co-pays **must** be paid at the time services are rendered, as this is our contractual obligation with your insurance company.

If you personally happen to receive payment from your insurance carrier, for services provided during the period which the office has accepted assignment of benefits, you are required to bring the insurance check and accompanying paperwork into this office within one week of receipt and endorse it over to our office.

If you discontinue your care for any reason, other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company. For any balances not paid by the due date, a monthly service charge of $10.00 will be applied each month that the balance is not paid in full. If payments are not made by the due date, our office will immediately initiate collection procedures.

This office does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim(s), it will be the patient's responsibility to pay the charges and pursue reimbursement from the insurance company.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions of this program as specified above.

Patient's Signature: _____ Date: _____
(Guarantor's Signature if minor)

Staff Signature: _____ Date: _____

INSURANCE INFORMATION WORKSHEET

Patient's Name: _____ Patient's DOB: _____

Relationship to Insured: _____

Insured's Name: _____ Insured's DOB: _____

Insurance Company: _____

Member ID#: _____ Alpha Prefix: _____

Group #: _____ Effective Date: _____

Deductible: $_____ Insurance %: _____

PMMP: Yes No NIA: Yes No

Service	Co-Pay	Stackable?	Visit Limits	Runs
Specialist Office Visit	$			Cal / Ben: __/__ to __/__
Physical Medicine	$			Cal / Ben: __/__ to __/__
Spinal Manipulation	$			Cal / Ben: __/__ to __/__

Other Information: _____

I have had my insurance benefits explained and understand my insurance benefits as it relates to chiropractic care provided to me by Dr. Brian Moreland and Back in Motion Chiropractic, LLC. I also understand that my insurance benefits may change from time to time, and it is my responsibility to notify the office of such changes. The above information is not a guarantee of my insurance company's willingness to pay benefits to the doctor. Benefits are still subject to the insurance company's determination that those services are medically reasonable and necessary.

Patient's Name (Printed): _____ Date: _____

Patient's Signature: _____ Date: _____
(Guarantor's Signature if minor)

Authorization to Use or Disclose Protected Health Information
Back In Motion Chiropractic, LLC

Patient Name:_____

Date of Birth:_____ Date of Request:_____

As required by the Privacy Regulations, Back In Motion Chiropractic, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize_____ and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of:

Back In Motion Chiropractic, LLC

Specific Patient Health Information authorized to be disclosed:

_____

_____

For the specific purpose of:
Evaluation and management

Effective dates for the authorization: _____/_____/_____ to _____/_____/_____ or until **all requested records are received.**

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*

_____ _____

Authorized Signature of Facility *Date*