DocBlack Family Chiropractic

Name_____ **Date**_____

Street_____**City**_____**State**_____ **Zip**_____

Phone_____**E-Mail**_____

Soc. Sec._____**Driver's Lic#**_____ **Sex:** ☐ **M** ☐ **F** **D.O.B.**_____ **Age**_____

Marital Status ☐ **S** ☐ **M** ☐ **W** ☐ **D** **Occupation**_____

Employer_____

How were you referred to our office?_____

Have you ever had chiropractic care before? ☐ **Yes** ☐ **No** **If yes, when?**_____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Complaint 2: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Complaint 3: _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does your condition interfere with your:

Work	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Sleep	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Daily Routine	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE
Recreation	☐ NO	☐ MILD	☐ MODERATE	☐ SEVERE

List other doctors consulted for condition:

1. _____ Address: _____
2. _____ Address: _____

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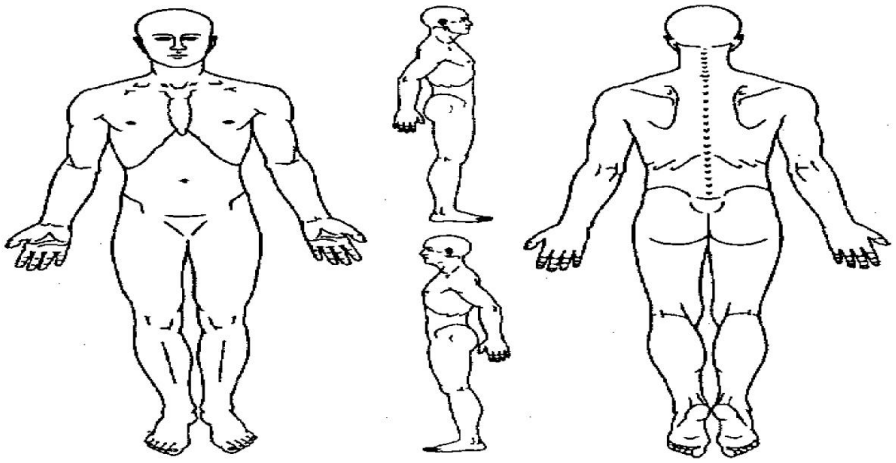
Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas



Health History (Check if you have ever had any of the following:)

- ☐ Abdominal Aortic Aneurysm
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ UTI
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other: _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

Is there anything else you think we should know about or that you would like to discuss? (Explain): _____

_____

_____

The information which I have provided is true and complete to the best of my knowledge and I will not hold Narragansett Family Chiropractic/CS Black Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____

Patient's Signature **Date** **Guardian's Signature**

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CONCERNS:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Please circle all that apply, **star your top 3** and add any others that are important to you.

Is it going to hurt?	I don't want to be cracked
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if chiropractic does not work?	Can this be fixed?

HABITS/STRENGTHS:

Strong habits are key to health. It helps us understand how you will heal when we know your health habits. Please circle all that apply, **star your top 3** and add any others that you may have.

Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body weight of ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green everyday	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker

GOALS:

We want to make sure you get lasting relief and help you in every way possible. Please circle any functional goals that you have, **star your top 3** and add any others that are important to you.

Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period

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Billing Information & Financial Policy:

Do you have insurance? ☐Yes ☐No Insurance Company_____

Subscriber?_____ Relationship to patient_____ID#_____

Subscriber's Employer_____ Subscriber's Date of Birth_____

Is there additional Insurance ☐Yes ☐No Insurance Co._____

Is this due to an accident or injury? ☐ Yes ☐ No Type of accident ☐Auto ☐Work ☐Home ☐Other_____

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to Narragansett Family Chiropractic/CS Black Family Chiropractic, Christopher S. Black, DC.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. I understand that an interest charge at the annual rate of 18% will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

Our office has may discontinue care if your balance becomes greater than $150. I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ **Date**: _____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date:_____

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PATIENT CONSENT FORM Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: Narragansett Family Chiropractic/CS Black Family Chiropractic/Christopher S. Black, DC. I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form. I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date:_____

Guardian (if under 18, please print):_____

Signature: _____ Date:_____

CONSENT TO TREATMENT OF A MINOR

Minor's Name:_____ Date of birth:_____

Name of Custodial Parent/Legal Guardian (please spell clearly):_____

Relationship to the minor: ☐ Custodial Parent ☐ Adoptive parent with custody ☐ Guardian by Law.

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Narragansett Family Chiropractic/ CS Black Family Chiropractic, Christopher S. Black, DC to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Narragansett Family Chiropractic/CS Black Family Chiropractic, Christopher S. Black, DC which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Address of Parent/Guardian:_____

Phone:_____ Date 0f Birth:_____

Signature:_____Date:_____

Witness' Name:_____Date:_____

Witness' signature:_____Date:_____