Cornerstone Chiropractic Center

Confidential Patient Information

Name:_____ **Birth Date**:_____ **Gender:** ***M F***

Home Address:_____

City:_____ **State**:_____ **Zip**:_____

Circle your primary contact preference:

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

E-mail Address:_____ Nickname:_____

SSN:___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Marital Status**: *M S W D* Number of Children:_____

Person to contact in case of an emergency:_____ **Phone**:_____

Your Occupation/Employer:_____ FULL TIME or PART TIME

Your Family Physician:_____ May We Contact? *Y N* Phone: _____

*Your Spouse/Parent:*_____ *Their SSN:*___ ___ ___ - ___ ___ - ___ ___ ___ ___

*Their Birth Date:*_____ *Address:*_____ *Phone:*_____

Whom may we thank for referring you to our office?_____ Relationship: _____

Who has your permission to receive information about your appointments, treatment, and/or billing info (usually family or significant other…)?_____

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Smoking Status?

- ☐ Current every day smoker _____ /day
- ☐ Current some days smoker ____ / week
- ☐ Former smoker – date quit: _____
- ☐ Never smoker

Family History? (Please list all major diseases such as cancer, diabetes, heart problems, bone/joint disorders, …)

Father:_____

Mother:_____

Sibling(s):_____

Grandparent(s):_____

Do you have any <u>MEDICATION</u> allergies?

- ☐ No known medication allergies
- ☐ Yes:_____
- ☐ Yes:_____

Are you <u>currently prescribed</u> any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes.

Please provide medication name and condition it is prescribed for:

1._____ For:_____

2._____ For:_____

3._____ For:_____

4._____ For:_____

5._____ For:_____

What <u>ONE area of pain or dysfunction</u> brings you here today?_____**Left or Right**

When did it start hurting most recently?_____**What were you doing at that time?**_____

_____

Have you ever had anything like this in the past? *YES NO* If yes, when and how did that occur?_____

_____

<u>Worst pain or dysfunction level for THIS EPISODE</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Aggravated by: (circle all that apply)
*Sitting Standing Coughing/Sneezing Walking Bending Twisting Sleeping Other:*_____

What activities of daily living is this condition affecting? _____

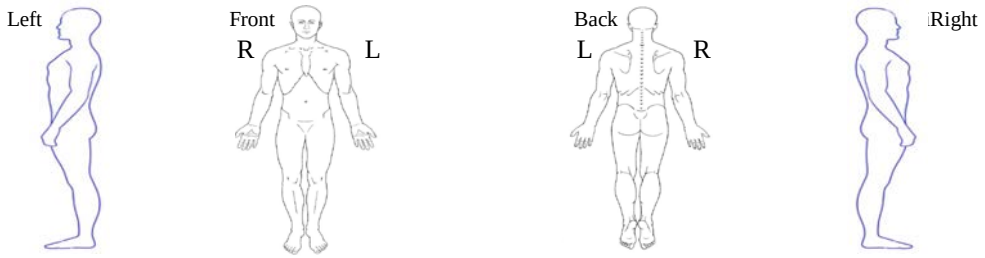
What other doctors/treatment/tests have you tried? _____

What was the outcome of the treatment or tests?_____
<u>Current pain or dysfunction level TODAY</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Describe your pain / dysfunction: (circle all that apply)
*Achy Burning Numb Pinching Popping Sharp Sore Stabbing Stiff Throbbing Tight Tingling Other:*_____

How often do you experience symptoms? (0-100)_____**% of the time** *Radiating from*_____*to*_____

What makes it feel better? (circle all that apply) *Rest Ice Heat Medication Other:*_____

Indicate your area(s) of pain:



Any <u>additional area of pain or dysfunction</u>?_____**Left or Right**

When did it start hurting most recently?_____**What were you doing at that time?**_____

_____

Have you ever had anything like this in the past? *YES NO* If yes, when and how did that occur?_____

_____

<u>Worst pain or dysfunction level for THIS EPISODE</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Aggravated by: (circle all that apply)
*Sitting Standing Coughing/Sneezing Walking Bending Twisting Sleeping Other:*_____

What activities of daily living is this condition affecting? _____

What other doctors/treatment/tests have you tried? _____

What was the outcome of the treatment or tests?_____
<u>Current pain or dysfunction level TODAY</u>: (NONE) *0 1 2 3 4 5 6 7 8 9 10* (UNBEARABLE)
Describe your pain / dysfunction: (circle all that apply)
*Achy Burning Numb Pinching Popping Sharp Sore Stabbing Stiff Throbbing Tight Tingling Other:*_____

How often do you experience symptoms? (0-100)_____**% of the time** *Radiating from*_____*to*_____

What makes it feel better? (circle all that apply) *Rest Ice Heat Medication Other:*_____

What types of exercise do you perform on a regular basis? _____

What do your daily work habits include? (Computer work, housework, light/heavy labor, travel, …)_____

_____

Check conditions which apply to ***your*** **Past medical history** or that you are **Currently under care** for:

P	**C**		**P**	**C**	
□	□	Arthritis:_____	□	□	High Blood Pressure
□	□	Asthma	□	□	High Cholesterol
□	□	Back Pain	□	□	HIV/AIDS
□	□	Bleeding Disorder:_____	□	□	Immune Disorder:_____
□	□	Broken Bones: _____	□	□	Menstrual Problems
□	□	Cancer:_____	□	□	Muscle Disorder:_____
□	□	Constipation and/or Diarrhea	□	□	Neck Pain
□	□	Depression	□	□	Neurological Disorder: _____
□	□	Diabetes:_____	□	□	Osteopenia or Osteoporosis
□	□	Digestive Problems	□	□	Pacemaker
□	□	Dizziness and/or Vertigo	□	□	Sinus Trouble
□	□	Epilepsy/Seizures	□	□	Sprains/Strains:_____
□	□	Headaches and/or Migraines	□	□	Stroke/TIA
□	□	Heart Problem:_____	□	□	Tinnitus
□	□	Hernia: _____	□	□	Other:_____

List any serious illnesses you have had or now have: _____

List any major accidents (auto, work, falls, …) you have had and the date each occurred: _____

_____

List all surgeries you have had and the approximate date each occurred: _____

_____

Special Diet (vegetarian, …)_____ **Alcohol:**_____/ week

Caffeine:_____/ day **Recreational Drug use:** Never Past Current

WOMEN ONLY: Taking birth control pills? *Y N* Are you pregnant? *Y N* (Due date:_____) Nursing? *Y N*

AUTHORIZATION: *I certify that all information I provide is thorough and accurate. I agree that I am responsible for full payment of all services rendered at this office to myself and/or my dependents. I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself, not between my insurance company and this office. I authorize Cornerstone Chiropractic Center to release any medical information and to complete any usual and customary reports and forms to assist in collection from my insurance company and/or any third party payer. I authorize my insurance company and/or any third party payer to pay Cornerstone Chiropractic Center directly. I understand that all delinquent accounts are subject to 1.5% interest per month and may be turned over to a collection attorney. I agree to pay the additional 33⅓% attorney fee as well as all costs incurred in the recovery of my debt.*

MISSED APPOINTMENT POLICY: *It is the policy of Cornerstone Chiropractic Center to assess a $35.00 missed appointment fee to patients who either do not come to their appointment or cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, however you will be charged for additional missed visits. We provide care for many individuals and missed visits result in time lost that could have been used to provide care for others.*

I have read, understand, and agree to the conditions of the above policies.

Patient / Guardian Signature:_____Date_____

Cornerstone Chiropractic Center

Dr. Donald P. Bresnahan

D.C., D.A.B.C.O., C.C.S.P., C.C.R.P.

Certified in Active Release Technique & Graston Technique

Patient Health Information, Treatment Consent, & Notice of Privacy Practices Acknowledgement

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records along with possible adverse effects associated with chiropractic treatment. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used and that you understand the inherent risks associated with chiropractic treatment. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the Notice of Privacy Practices that is available to you at the front desk before signing this consent. Additional information on the effects and effectiveness of spinal adjustments is available upon request.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat and cold application, electrotherapy, stretches, exercises, and manual muscle therapies) are considered safe and effective methods of care. While the chances of experiencing adverse effects are small, it is our practice to inform our patients about the possibilities. Side effects include, but are not limited to, soreness, bruising, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustment (manipulation) is debated.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. A copy of the Notice of Privacy Practices has been made available to me. I have also read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature of Patient Date

1917 Laskin Road, Suite 108, Virginia Beach, VA 23454 * Phone: (757) 491-4600 * Fax: (757) 491-0578

ASSIGNMENT OF BENEFITS

Financial Responsibility

I have requested professional services from Dr. Donald P. Bresnahan at Cornerstone Chiropractic Center ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and understand that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me and/or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization (as applicable)

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or clause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 CFR § *2560.503-1(b)(4))* with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of the Assignment/Authorization shall be as effective and valid as the original.

Signed:_____ Date:_____

Printed Name:_____

Witnessed:_____ Date:_____