Chiropractic Spa / Dr. Melissa Raigan

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HEALTH INFORMATION FORM

The following information is needed to better serve you. Please print and complete all questions. If you need help, please ask the receptionist.

Name _____ Date of Birth _____Marital Status: S M W D

Address _____ City _____ State _____ Zip_____

Email _____ Primary Phone_____C/H/W

Referred by: _____ Secondary Phone_____C/H/W

Employer_____Occupation_____Years on Job_____

Employer Address_____City_____State_____Zip_____

Insurance Company_____ Do you have Medicare? YES OR NO

Primary Care Physician_____ Phone number_____

Spouse/Parent Information (Please fill this section out if you are not the primary card holder)

Name of Spouse/Parent_____ Date of Birth_____

Is this Health Insurance from work? YES or NO

How will payments be made?

Cash Check Credit Card Health Insurance Worker's Comp Auto Insurance

Is your condition due to an accident? YES OR NO Date of Accident_____

Type of Accident? Auto On Job At home OTHER: _____

Have you ever been in an auto accident? Past year? Past 5 years? Over 5 years? Never?

I(We) agree to pay for services rendered to above named patient as the charges is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of all services covered or not covered. I also understand if I suspend or terminate my care and treatment, any fee for professional services rendered by me will be immediately due and payable.

Patients signature:_____ Date:_____

Or Guardian signature:_____ Date:_____

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangement s should be made in advance before seeing Doctor and/or therapists.

Chiropractic Spa/Dr. Melissa Raigan 1210 Park Dr., Ste 100 - Mandeville, La. Phone 985-302-7555

Patients Name:_____ **Date:**_____

Full Body Questionaire

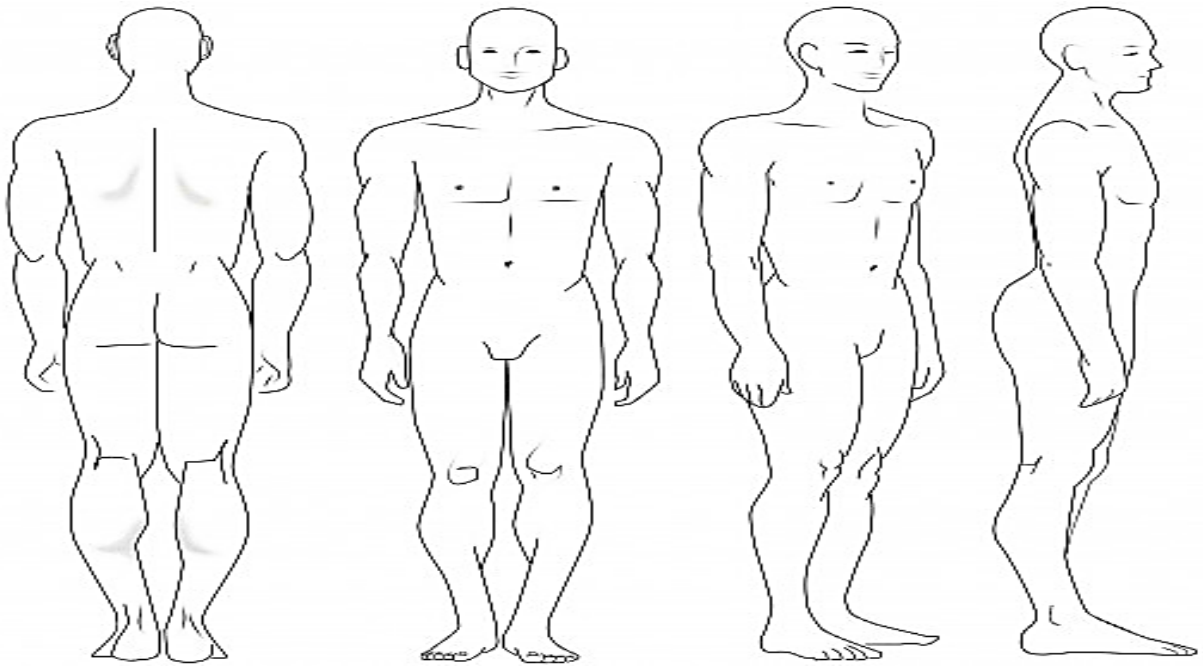
Major Complaint #1_____
When did this start?_____
Does anything aggravate it?_____
Does anything relieve it?_____
Can you describe the pain?_____
Does it radiate and to where?_____
How often do you feel it?_____

Major Complaint #2_____
When did this start?_____
Does anything aggravate it?_____
Does anything relieve it?_____
Can you describe the pain?_____
Does it radiate and to where?_____
How often do you feel it?_____

Major Complaint #3_____
When did this start?_____
Does anything aggrevate it?_____
Does anything relieve it?_____
Can you describe the pain?_____
Does it radiate and to where?_____
How often do you feel it?_____

History: Injuries / Fractres/ Surgeries_____
_____
_____

Please draw on the model exactly where your pain is



In order to maximize the effectiveness and safety of your treatment, please take the time carefully to fill out this questionnaire. This information will be treated confidentially.

Have you had a professional massage before?_____Have you had an adjustment before?_____

What are the expectations of this service? _____

_____

Do you experience any difficulty lying on your front or back?_____

_____

Is there any area you where you would like more time spent or hold a lot of tension?_____

Do you have difficulties with aromas? If so which ones?_____

Do you smoke? _____If so, how much?_____

Do you drink alcohol?_____If so, how much and often?_____

Do you exercise?_____What type? If so, how often?_____

Are you pregnant?_____If so, how far along?_____

How many ounces of caffeine do you have daily?_____ How many ounces of water daily? _____

How many hours a night do you sleep?_____What posture do you assume most of the day?_____

Check all that apply to you

Hypertension_____	**Heart disease_____**	**Artheriosclerosis___**	**Varicose veins_____**	**Plebitis_____**
Cancer_____	**Diabetes_____**	**Easy bruising_____**	**Skin rash_____**	**Open sore_____**
Herpes I or II_____	**Mental Illness_____**	**Osteoporosis_____**	**Arthritis_____**	**Hepatitis_____**
Inner ear _____	**HIV_____**	**Epilepsy_____**	**Epstein Barre_____**	**Fibromyalgia_____**
Radiation_____	**PMS_____**	**Blood thinner_____**	**Chemotherapy_____**	**Lupus_____**
Skin sensitivity_____	**Headaches_____**	**Herniated disc_____**	**Chronic fatigue____**	**Allergies_____**

Surgery or fractures?_____Where?_____

Are you under medical supervision?_____If so for what? _____

List medicines_____

Print Name of Patient: _____

Signature of Patient: _____ Date: _____

Consent for Chiropractic Treatment and Acknowledgement of Receipt of Information

To the Patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors and massage therapist, are required, by law, to tell you the nature of your condition, the general nature of treatment. the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign confirmation that Dr. Missy/Chiropractic Spa has discussed all these matters.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities (including but not limited to massage therapy). Although their occurrence is extremely rare, some risks are known to be associated with these procedures. Which includes the following: stroke (dizziness, unconsciousness, visual problems, speaking difficulty, swallowing, difficulty walking, vomiting, numbness), disc herniation, soft tissue injuries, and rib fractures.

Health Insurance Portability & Accountability Act (HIPAA)

Notice of Privacy Practices - Revised November 2016 Version 8

Your medical information is personal, and Chiropractic Spa is required to keep this information confidential and to maintain a record of the care and services you receive at the clinic. This notice applies to all records of your care generated within our clinic. If there is an instance where Chiropractic Spa needs to share your healthcare information with other health care professionals, you will be asked to sign a separate consent form.

As per HIPAA, Chiropractic Spa has copies of the full HIPAA available. If you would like to read or have a copy in its entirety, please feel free to ask for a copy.

AUTHORIZATION, ASSIGNMENT, AND RELEASE FORM

In consideration to release of your services for your care, I agree to the following:

To allow Chiropractic Spa to release any information concerning my physical condition to any insurance company, attorney, or other responsible parties. I authorize the direct payment to you of any sum for services rendered I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case and/or by any insurance company obligated to make payment to me or you based in whole or in party upon the charges made for services. In the event any insurance company, attorney, or other responsible parties are obligated by contractual agreement to make payment to me or to you for services rendered, refuses to pay upon demand I authorize Chiropractic Spa to settle any claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company, attorney, or other responsible parties, you will refrain from collecting the amounts owed directly from me. Also, I understand that whatever amounts you do not collect from the insurance company, attorney, and/or other responsible parties, whether it be all or part of what is due I personally owe and agree to pay you.

In addition to the above, I hereby waive the statues of limitations on collections and/or recovery from any state. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

Print Name of Patient: _____
Signature of Patient: _____ Date: _____

Personal Representative of the Patient
Print Name: _____Relationship to Patient: _____
Contact #: _____

In case of an emergency in our office, I give permission to contact:

Print Name: _____ Phone #_____

CANCELATION POLICY

We ask that you give a 24 hour cancellation notice if you are unable to make your scheduled appointment time. We understand that life happens at a moment's notice and for last minute excusable absences, you will not be charged unless they become excessive.

If you are unable to give a 24 hour notice, we still encourage you to call or text us. This allows us to try and fill your appointment time. If we are able to fill your appointment, we do not consider it an absence. We allow 1 unexcused absence of any appointment. After that, we charge $45 for missing a massage and $25 for a missed adjustment. We will continue to charge either $45 or $25 for all future unexcused absences throughout the calendar year.

If repeat tardiness becomes abused, we will charge $35 for missing 30 minutes of the massage and $20 for missing 15 minutes of the massage as it is illegal to charge your insurance for service time you did not receive.

Thank you for choosing us to serve your massage needs. We greatly appreciate your consideration of our Chiropractor and Massage Therapists schedule and pay.

Print Name of Patient: _____

Signature of Patient: _____ Date: _____