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___________________

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

Name of Spouse/Parent______________________________________ Date of Birth____________________

Is this Health Insurance from work? YES or NO

<u>How will payments be made?</u>

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.

Patients Name:____ **Date:**___________________

Full Body Questionaire

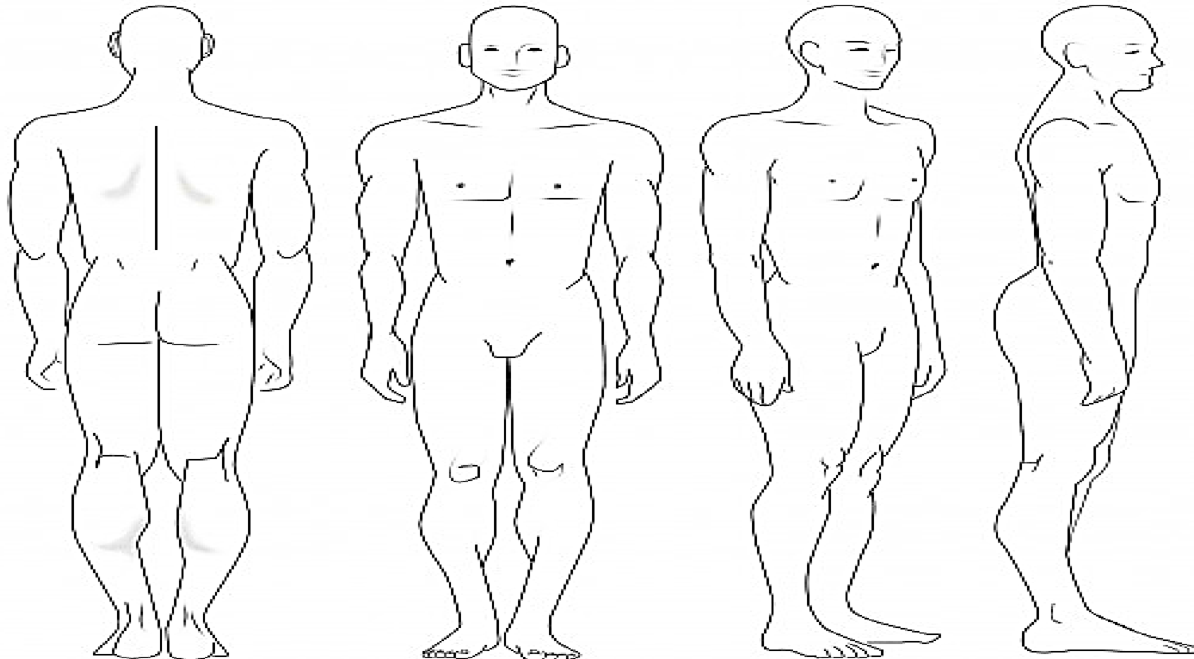
Major Complaint #1____
When did this start?____
Does anything aggravate it?____
Does anything relieve it?____
Can you describe the pain?____
Does it radiate and to where?____
How often do you feel it?____

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



Massage Form

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

Name ____________________________________ Date of Birth ______________Marital Status: S M W D

Address ____________________________________ City _________________ State ______ Zip_________

Email ____ Phone_______________________________C/H/W

Referred by: _________________________________ Occupation_________________________________

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____

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, 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 has discussed all these matters.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. 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.

Signature of Patient: ____________________________________ Date: ____________________