Landers Family Chiropractic
1146 N Brindlee Mtn PKWY, Arab, AL 35016
Phone: (256) 586-5322 Fax: (256) 931-4277

PATIENT INFORMATION

Patient Legal Name: _____ **Prefers to be called:** _____ **Today's Date:** ___/___/___

Social Security Number _____ **Driver's License #** _____ **Birth Date:** ___/___/___ **Age:** ____ **Gender: F M**

How did you learn about us? _____ **If you were referred, by whom?** _____

If you are under 18 years of age, who are your legal parents or guardian?

Parent/Legal Guardian: _____ *Relationship:* _____ *Phone (____)* _____

Social Security Number: _____ *Driver's License #* _____ *Date of Birth:* _____

Who do you normally live with? ☐ *Mother and Father* ☐ *Father* ☐ *Mother* ☐ *Legal Guardian* ☐ *None of these*

Marital Status: ☐ **Married** ☐ **Separated** ☐ **Widowed** ☐ **Single** **How many children?** _____

Address _____

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

Home Phone (_____) _____ **Cell Phone (_____)** _____ **Preferred Phone (circle one): HOME CELL**

Email _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Demographical Information:

Preferred Language: ☐ English ☐ Other (please list): _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Other (please list): _____

Ethnicity: ☐ Decline to Answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Check all that apply): ☐ Decline to Answer ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ African American ☐ Native Hawaiian/Other Pacific Islander

Smoker Status: ☐ Smoke Daily ☐ Smokes Often ☐ Former Smoker ☐ Never Smoked

WOMEN ONLY: Are you currently pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN **Initials:** ____

******Have you seen any other Chiropractor during the last 12 months: ___ Yes ___ No***

If Yes, Whom: _____

FAMILY HEALTH HISTORY

1. Have any immediate family members been diagnosed with a life-threatening illness? _____
2. At what age did they receive that diagnosis? _____
3. Were any family members diabetics? _____
4. Is there a history of heart disease in the family? _____
5. Has there been a diagnosis of mental illness? If so, what was the condition and who has been diagnosed with it?

_____

6. Have family members been struggling with other issues such as asthma, high blood pressure, alcoholism, or other substance abuse?

_____

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PATIENT CONDITION FORM

What type of pain/condition are you experiencing?

_____

Describe your pain: ☐ Burning Pain ☐ Sharp Pain ☐ Dull Pain ☐ Ache ☐ Other _____

Is your pain/condition or injury due to a(n): ☐ Auto Accident When: _____ City, State: _____

(Check one) ☐ Work Related Accident When: _____ City, State: _____

☐ No Accident When did you first notice your condition? _____/_____/_____

What makes it worse? _____

What makes it better? _____

Have you ever had the same or similar condition? □ YES □ NO If yes, when? _____

Please list any other healthcare provider you've seen for this condition, and when you last saw them: (use back if more space is needed)

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Are you currently suffering from:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness hands/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw Pain
☐ Loss of Strength – arms	☐ Burning Muscle Pain	☐ Loss of Strength – legs	☐ Difficulty Swallowing	☐ Sharp/shooting pain	

Have you experienced changes to:

☐ Eyes (sight)	☐ Ears (hearing)	☐ Nose (smell)	☐Respiratory (Breathing)	☐ Mouth (taste)
☐ Bladder	☐Bowels	☐ Sleep	☐ Emotion	☐ Appetite

Please explain: _____

Do you now or have you ever had:

☐ Heart Disease	☐ Stroke	☐ High Blood Pressure	☐ Thyroid Problems
☐ Tuberculosis	☐ Prostate Disorder	☐ Kidney Problems	☐ Seizure Disorder

Have you missed work or school as a result of your injuries? □ YES □ NO

Do you drink alcohol? □ YES □ NO Drinks/Week: _____ Do you smoke? □ YES □ NO Packs/Day: _____

List your nutritional goals: _____

Are you currently taking any medications (including regularly taken over the counter medications)?

☐ Check this box if you are not taking any medications.

Medication Name	Dosage	Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ☐ Check this box if you have no medication allergies.

Medication Name	Reaction	Onset Date	Additional Comments

Patient's Signature: _____ **Date:** ___/___/____

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OFFICE FINANCIAL POLICY

We charge $20.00 for any missed appointment that is a NO CALL, NO SHOW.

WHEN INSURANCE IS NOT PRESENT: It is customary to pay for professional services when rendered. It is our policy that payment be made at the time of each visit unless alternate payment arrangements are made. **WHEN INSURANCE IS PRESENT: Verification of benefits does not guarantee third party payments!** If you have insurance, we will gladly file your insurance claim for you. We cannot guarantee third party insurance payment, however we will do our best to give you an estimate of what your insurance may cover. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company. If the patient is referred to another specialist or discontinues care for any reason, the bill is due and payable in full immediately, regardless of any claims submitted. If a balance remains on the patient's account for more than 90 days, it will be turned over to a collections agency. If after all claims have been completed, we will contact you if a balance or credit remains on your account. Please allow 3-8 weeks for full processing of all claims. **GENERAL POLICIES:** A $35 fee for any returned checks will be charged to the patient's account. Full balance including returned check fee will be due immediately. All patients are on a cash basis until their respective insurance coverage and deductible may be verified. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you are discharged or choose to discontinue care; we will send three statements in attempt to collect any outstanding balance. We require a minimum monthly payment of $20 to avoid collections proceedings. Once three statements have been mailed and no payment has been received, your account will be turned over to a collections agency. By signing below, you acknowledge that your account will also be assessed an additional $20 fee for the cost of collections.

I authorize and instruct ClearGage, LLC (my Provider's billing administrator) to obtain and review my RiskView ™ Report from LexisNexis, which Report draws upon public records and proprietary data sources of LexisNexis. I understand that this RiskView ™ Report will assist in the evaluation of my creditworthiness, may be used to obtain credit and payment history, and be used to verify my past credit or payment history information. I understand, agree, and hereby give my consent that: (1) my Provider will provide information about me, including my name, address, phone and cell phone numbers, age birthday, sex, and Driver's License number to ClearGage, LLC, which will provide said information to LexisNexis, (2) information derived from this RiskView ™ Report will be shared with ClearGage, LLC, my Provider, and third party lenders; (3) information derived from this RiskView ™ Report will be used in the determination of whether my Provider will over me a payment plan; (4) my authorization for the RiskView ™ Report is not an offer of a payment plan and is not a guarantee of any such offer. Likewise, my consent does not constitute my agreement to any payment plan or payment terms; and (5) if I am offered a payment plan, at that time, the terms will be disclosed to me and I can choose whether to accept or reject it. I also understand that I may request a copy of my RiskView ™ Report by writing LexisNexis at: LexisNexis Risk Solutions Bureau LLC, RiskView Consumer Inquiry Department, P.O. Box 105108, Atlanta, GA 30348-5108 (866) 897-8126

By signing below, it states that you have read and understand the Office Financial Policy and agree to abide by these terms.

Patient Signature: _____ Date: ____/____/_____

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INFORMED CONSENT

We want you to be informed about the care in which you may receive, including risks and benefits. This information is given so that you may be knowledgeable about your choice to consent to chiropractic care.

Risks & Benefits of Care:

I understand and am informed that in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. In the majority of cases chiropractic care offers multiple benefits including the relief of neck pain, headaches and low back pain.

Alternative Treatments including risks and benefits:

Alternative treatments include, but may not be limited to, massage therapy, physical therapy, medication, or surgery. The risks involved with these alternative treatments should be discussed with practitioners within the relative field. Chiropractic care offers a non-invasive, natural treatment of vertebral misalignments.

Risks of no treatment at all:

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand and have read (or had read to me) the risks listed above. I acknowledge that the doctor was open with me about the risks of chiropractic and was willing to answer any questions that I have (or may have in the future). I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: ____/____/_____

(If patient is a minor, consent must be signed by parent or official guardian)

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/_____

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Additional Information

Please check all that apply:

___ **The patient is between the ages of 15 and 18.**
(Please complete the Medical Treatment Authorization and Consent Form)

___ **The patient has x-rays, MRIs or other records they would like to be released to Landers Family Chiropractic.**
(Please complete an Authorization to Release Records Form)

___ **The patient has retained an attorney and is currently in litigation for an auto accident.**
(Please complete Attorney Information & Auto Accident Questionnaire Form)

___ **The patient will need a doctor's excuse for ___ work ___ school.**
___ Once ___ Every Visit ___ Only Upon Request From Patient
(You will receive a doctor's excuse at the time of check-out)

___ **The patient will need someone else to have access to their health records in this office other than the parents or authorized guardian.**
(Please complete a HIPPA Release Form)

- I acknowledge that I have the right to request a copy of Landers Family Chiropractic's Notice of Privacy Practices Policy. I consent to the use and disclosure of my protected health information as specified in Landers Family Chiropractic's Notice of Privacy Practices Policy.

- I understand that in the event I miss an appointment I give consent to Landers Family Chiropractic to send me a postcard regarding that appointment. I understand that I can request in writing an alternate form of communication.

- I understand that my records (including x-rays) are the property of Landers Family Chiropractic and if at any time I request a copy of my records there will be an additional charge for copying them (including x-rays).

- By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my heath care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my health care provider to disclose to third-parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

Patient Signature: _____ **Date:** ____/____/_____