(517) 543-2920
(517) 543-1221 Fax

432 N. Cochran Avenue
Charlotte, Michigan 48813

CONFIDENTIAL PATIENT INFORMATION

Date ____________________

Name ______________________________ Social Security ____________________

Address ____________________ City ____________________ Zip Code ____________

Home Phone ____________________ Cell Phone ____________________

E-mail Address ____

Age ________ Birth Date ____________ Marital : M S W D How many children? ____________

Occupation ____________________ Employer ____________________

Address ______________________________ Work Phone ____________

Name of Spouse ____________________ Occupation ____________________

Employer ____________________ Address ____________________

Patient's Nearest Relative ____________ Address ____________ Phone ____________

Referred by ____

Is condition due to injury or sickness arising out of patient's employment? ____________________

Date symptoms appeared or accident happened: ____________ Have you lost any days from work? ____________

Date of last physical examination: ____________________ Female: Are you pregnant? ____________

What operations have you had? ____

Serious illnesses? ____________________ Fractured bones? ____________

Have you ever been under Chiropractic Care? Yes ❑ No ❑ Doctor's Name ____________________

Have you ever suffered from:

- ❑ Allergy
- ❑ Dizziness
- ❑ Fatigue
- ❑ Headaches
- ❑ Loss of sleep
- ❑ Ulcers
- ❑ Nervousness/Depression
- ❑ Numbness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Foot trouble
- ❑ Low back pain

Tingling or numbness in:

- ❑ Shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

- ❑ Neck pain or stiffness
- ❑ Poor posture
- ❑ Sciatica
- ❑ Spinal Curvatures
- ❑ Swollen joints
- ❑ Colon trouble
- ❑ Diarrhea
- ❑ Difficult digestion
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Asthma
- ❑ Colds
- ❑ Deafness
- ❑ Ear noises
- ❑ Enlarged thyroid
- ❑ Eye pain

- ❑ Failing vision
- ❑ Tuberculosis
- ❑ Bruise easily
- ❑ Hay fever
- ❑ Nosebleeds
- ❑ Sinus infections
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ Anemia
- ❑ Strokes
- ❑ Chest pains
- ❑ Difficulty breathing

- ❑ Pleurisy
- ❑ Swelling of ankles
- ❑ Cancer
- ❑ Varicose veins
- ❑ Bed-wetting
- ❑ Frequent urination
- ❑ Kidney infection or stones
- ❑ Prostate trouble
- ❑ Cramps or backache
- ❑ Excessive menstrual flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Lumps in breast
- ❑ Alcoholism
- ❑ Diabetes
- ❑ Polio

HABITS:	Heavy	Moderate	Light	None
Alcohol	____	____	____	____
Coffee	____	____	____	____
Tobacco	____	____	____	____
Drugs	____	____	____	____
Exercise	____	____	____	____
Sleep	____	____	____	____

DO YOU:

Now take vitamins or minerals? Yes ____ No ____

Think you may need vitamins or minerals? Yes ____ No ____

Are you wearing: Heel lifts ____ Sole lifts ____
Inner soles ____ Arch supports ____

PLEASE PRINT:

What is your primary complaint? ______

What activities aggravate your condition? ______

Is this condition getting progressively worse? Yes ____ No ____ Constant ____ Comes and goes ____

Is this condition interfering with your Work ____ Sleep ____ Daily routine ____ Other ______

______

How long has it been since you really felt good? ______

What do you believe is wrong with you?

______

Other doctors seen for this condition ______

Have you had this condition before? Yes ____ No ____ If yes, when and described ______

______

Have you been treated for any health conditions by a physician in the last year? Yes ____ No ____

Describe ______

What medications or drugs are you taking? ______

Remarks and additional information ______

______

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment ______

Are you insured? Yes ____ No ____ Name of Insurance Company ______

Insured's name if patient is a dependent ______ Social Security ______

Policy holder's date of birth ______

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropratic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature ______ Date ______

Guardian or Spouse's Signature Authorizing Care ______ Date ______

Information Taken by ______

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of any disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,___________________________ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_______________________________ _______________________________
(Signature) (Date)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION FOR HEALTH INSURER OR HEALTH BENEFIT PROVIDER TO PAY DOCTOR/CLINIC DIRECT

The undersigned acknowledges that he/she has requested treatment from Dr. Kevin T. Davis, or DAVIS CHIROPRACTIC CENTER, and in consideration thereof agrees to be fully and personally responsible for all charges incurred regardless of whether or not said charges could be partially or completely covered by health insurance or any other forms of insurance.

As a courtesy to our patients, Davis Chiropractic Center will, under appropriate circumstances, process a request for payment of services rendered on behalf of the patient and send it directly to the patient's health insurer or other health benefits provider.

The undersigned patients does, by his/her signature hereon, authorize the health insurer or other health benefits provider, as identified below, to make direct payment to Dr. Kevin T. Davis or Davis Chiropractic Center for all provided, verified, and covered Chiropractic services rendered to and for my benefit.

In the event that Chiropractic reports and/or other records are required to process the request for direct payment as hereinabove provided, I do, by my signature hereon, authorize Dr. Kevin T. Davis or Davis Chiropractic Center to release any information pertinent to my case that may be requested by a health insurer or other health benefit provider.

This authorization to pay doctor/clinic directly shall remain in full force and effect until such time as my health insurer or other health benefit provider and Dr. Kevin T. Davis or Davis Chiropractic Center is notified, in writing, that said authorization is cancelled.

________________________ ______________ ________________________

Patient or Guardian Signature Date Witness

____

Social Security Number

____

Health Insurer/Benefit Provider

Dear Patient:

Our credit policies have been established to ensure that the best service can be provided to you and your family and any misunderstanding can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid for by the insurance company. With or without insurance coverage, you are responsible for full payment of your total bill.

PAYMENT IS DUE AND PAYABLE AS SERVICES ARE RENDERED.

For your convenience, our office has made arrangements with Care Credit, and we are now able to offer low monthly payments to our valued patients.

PLEASE INDICATE IN WHICH MANNER YOU WISH US TO HANDLE YOUR ACCOUNT:

1.________ I will pay the day of treatment by cash, check, Visa, or Master Card.

2.________ I have insurance and will pay my portion the day of treatment.

3.________ I have insurance and will apply for Care Credit to cover my portion.

4.________ I have no insurance and will apply for Care Credit.

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of .005% per month, which is an annual percentage rate of 6% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

______________________________________ ______________

Patient or Guardian Signature Date

____

Witness

NOTICE TO OUR PATIENTS

As of April 13, 2003, all health care providers are required by the Federal Government to advise you how this office uses your health information.

The entire 6-page notice is displayed in our reception room if you choose to read it in its entirety. We will also provide patients with the entire notice, in brochure form, upon request.

An abridged edition is being given to you to view, covering the major points.

Nothing in this notice changes the way we provide care, obtain payment, or run our office.

Please read the abridged notice and sign the Acknowledgement form, which explains that we have made you aware of this Federal policy. Please return it to the reception desk when you leave today.

If you have any questions, please ask any staff member.

Thank you,

Davis Chiropractic Center

DAVIS CHIROPRACTIC CENTER
NOTICE OF PRIVACY PRACTICES
Abridged Edition

Effective April 14, 2003, the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law. You have the right to revoke this authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

Required by law	Public Health	Communicable Diseases
Health Oversight	Abuse or Neglect	Food & Drug Administration
Legal Proceedings	Law Enforcement	Military Activity & National Security
Research	Workers' Compensation	

YOUR RIGHTS

YOU MAY INSPECT OR OBTAIN A COPY OF YOUR PROTECTED HEALTH INFORMATION FOR AS LONG AS WE MAINTAIN THAT INFORMATION UNLESS PROTECTED BY FEDERAL LAW.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations.

RIGHT TO OBTAIN A PAPER COPY OF OUR PRIVACY PRACTICES NOTICE

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services.

This notice was published and becomes effective April 14, 2003.

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that Davis Chiropractic Center's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Davis Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Davis Chiropractic Center.

The Notice of Privacy Practices for Davis Chiropractic Center is also provided on request at the main administration desk of this practice and on Davis Chiropractic Center's website at www.davis-chiro.com. This Notice of Privacy Practices also describes my rights and Davis Chiropractic Center's duties with respect to my protected health information.

Davis Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Davis Chiropractic Center's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

____ ______________

Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority