Name _____ Date _____

Address _____ Social Security # _____

City _____ State _____ Zip _____ Occupation _____

Phone: (H) _____ (W) _____ Employer _____

(C) _____ Marital Status S M D W

E-mail _____ Spouse's Name _____

Date of Birth _____ (Age _____) Spouse's Occupation _____

Name of Emergency Contact _____ Relationship and Phone _____

How many children?_____ Names and Ages of Children:_____

_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

Major Medical Medicare Auto Accident Other:_____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

Primary Insured's Name: _____ Primary Insured's DOB: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

History of Present and Past Illness

Chief Complaint: Purpose of this appointment:_____

Date of symptoms appeared or accident happened:_____

Is this due to: Auto_____ Work_____ Other_____

Have you ever had the same or similar condition? Yes No If yes, when and describe:

_____

Days lost from work:_____Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):_____

_____

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

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? Yes No

If yes, describe:_____

Do you have any allergies of any kind? Yes No

If yes, describe:_____

Do you have any congenital condition? Yes No

If yes, describe:_____

Women: are you pregnant?_____

Have you had any surgeries? If so, please list all surgeries: _____

_____

_____

_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now		**P = Previously**
Headaches	_____ Frequency_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Cold Feet	_____
Tension	_____	Cold Hands	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____

N = Now **P = Previously**

Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in toes	_____	Diabetes	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Ulcers	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

Social History

Please indicate beside each activity whether you engage in it:

O = Often **S = Sometimes** **N = Never**

Vigorous Exercise	_____	High Stress Activity	_____
Moderate Exercise	_____	Family Pressures	_____
Alcohol Use	_____	Financial Pressures	_____
Drug Use	_____	Other Mental Pressures	_____
Tobacco Use	_____	Other (specify)	_____
Caffeine	_____	_____	

Financial Policy of Cobb Family Chiropractic PLLC

Chiropractic care is covered under most insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients without Insurance

We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been made. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, check, or credit card.

Group or Individual Insurance

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles, or copays.

Worker's Compensation

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance; however, we DO NOT accept Worker's Compensation.

Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if any attorney is representing you. Although you are ultimately responsible for your bill, we will wait for reasonable settlement time of your claim. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you do not have secondary coverage, you are required to pay the deductible and the remaining 20% as well as any non-covered services. If you have secondary coverage, they will pay the remaining 20%. Our office completes and files the forms for Medicare at no charge.

I have read and understand the payment policy of Cobb Family Chiropractic PLLC. I certify that the insurance information that I have provided is accurate, complete, and current and that no other cover or insurance plan exists. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Cobb Family Chiropractic PLLC and my insurance company.

I assign my right to receive payment of authorized benefits to Cobb Family Chiropractic. I request that payment of authorized benefits be made on my behalf to Cobb Family Chiropractic for any services furnished to the patient listed below by Cobb Family Chiropractic. I authorize Cobb Family Chiropractic to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.

If my Health Insurance Plan will not direct payment to Cobb Family Chiropractic, I agree to forward to Cobb Family Chiropractic all health insurance payments which I receive for the services rendered by Cobb Family Chiropractic and its health care providers.

I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Cobb that fees will be due and payable immediately.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Health Information Consent Form (HIPAA)

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. 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. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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 effect 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. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Signature: _____ Date: _____

Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and, if necessary, diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by the Chiropractor and/or anyone working in this office authorized by the Chiropractor. I further understand that such chiropractic services may be performed by the Chiropractor and/or other licensed Chiropractors who may treat me now or in the future at this office. I will have an opportunity to discuss with **Dr. Michele Cobb** and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the Chiropractor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the Chiropractor to exercise judgment during the course of the procedure which the she feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my Chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient and/or the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____