University Chiropractic and Wellness, LLC

Patient Information:

Last Name: _____First Name: _____(M): _____

Address: _____City: _____

Apt#_____ State: _____ Zip: _____

Birth Date: _____/_____/_____ SS#_____/_____/_____

Cell Phone: _____Home Phone: _____Work Phone: _____

Occupation: _____Employer: _____

Responsible Party: Self ☐ Parent ☐ Spouse ☐ Parent or Spouses, DOB_____/_____/_____

Name of Responsible Party if not patient: _____ DOB:_____/_____/_____

****If you are a student please put your parents' home mailing address if not listed above:**

_____

How were you referred to our office? (Please X one of the following)
_____Friend, family member or a patient. May we have their name, so we can send them a thank you letter.

Referrer's Name: _____

If you weren't referred by a friend or family member, how did you find our office?

_____Google Search _____Office Sign _____Attorney _____Another Physician

_____yelp _____Groupon ____Facebook Other_____

Have you ever been to a Chiropractor before? ☐ yes ☐ no
If yes, for what and how long ago_____

Please X any and all Insurance coverage that may be applicable in this case:
☐Major Medical (Blue Cross or other Health Insurance) ☐Workman's Compensation
☐Medicare ☐Personal Injury (attorney) ☐Automobile Insurance Policy (MedPay)
☐Check, Credit Card and/or Cash

Name of Primary Insurance: _____

Who is the Policy Holder of Primary Insurance: **Patient ☐ or Responsible Party ☐**

Name of Secondary Insurance Company (if any):_____

Who is the Policy Holder of Secondary Insurance: **Patient ☐ or Responsible Party ☐**

Your E-mail address: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at our office? ☐ yes ☐ no
If yes can we have the name of your Family Medical Doctor: _____

UNIVERSITY CHIROPRACTIC AND WELLNESS

Accident History Questionnaire

Patient's Name: _____ Date of Accident: ____/____/____

List and describe your symptom(s) below: Were You: □**Driver** □**Passenger** □**Pedestrian**

1. (Worst) _____
2. _____
3. _____

Place an "X" on the line below to indicate the level of pain for your worst symptom

No Symptoms ----------**Extreme Symptoms**

Did you have any of these symptoms prior to the accident: □**No** □**Yes** If yes, please describe: _____

_____

Has there been a previous injury to the above areas? □**No** □**Yes** If yes, please describe: _____

_____

Are the symptoms: □**Constant** or □**Come & Go** Since the onset, are the symptoms: □**Better** □**Worse** □**Same**

Describe some things that can make the problem worse: _____

Describe some things that can relieve the problem (even temporarily): _____

Have you been able to work since the accident? □**No** □**Yes** If no, list the dates missed: _____

Describe the accident in full detail: _____

_____

_____

_____

_____

Did you have your seatbelt on? □**No** □**Yes** Your vehicle (make/model): _____

Did you go to the E.R. after the accident? □**No** □**Yes**

Has there been another doctor(s) (besides our office & the E.R.) consulted for your injuries? □**No** □**Yes** If yes, please list their names: _____. Are you still under their care? □**No** □**Yes**

As a result of the accident, were traffic citations issued to you? □**No** □**Yes**

Have you been contacted by an insurance adjustor regarding this claim? □**No** □**Yes**
If yes, adjustor's name: _____ Phone #: _____ Company _____

Are you represented by an attorney? □**No** □**Yes** If yes, who? _____

_____/___/____
Signature **Date**

UNIVERSITY CHIROPRACTIC AND WELLNESS

INSURANCE 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.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

PRIVACY NOTICE

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

RECORDS RELEASE AUTHORITY

I, _____, hereby request that _____ provide:
_____a copy of the report for my MRI/CT scan and/or any other radiological tests
_____a copy of all my medical notes pertinent to the treatment of my _____ to

Dr. Matthew S. Hitchner at University Chiropractic and Wellness.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____

NO-SHOW APPOINTMENT POLICY

We work hard to see patients on time. If you are unable to keep your appointment, please call us 12 hours in advance if you need to reschedule or cancel your appointment so we can offer the time reserved for you to someone else who needs it. Generally, we cannot fill appointment spots with less than 12 hours notice. We will charge a $25 missed appointment fee for missed or cancelled appointments with less than 12 hours notice.

Patient Signature:_____ Date:_____/_____/_____
Guardian's Signature Authorizing Care:_____ Date:_____/_____/_____