Patient Information (UHC):

Last Name:_____First Name:_____(M):_____
Address:_____City:_____
State:_____Zip:_____Birth Date:_____/_____/_____ SS#____/____/_____
Home Phone:_____Cell Phone:_____

Responsible Party: ☐Self ☐Parent: Parents DOB____/____/____ ☐Spouse: Spouse 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_____

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

· Google Search · Office Sign · Attorney · Physician · yelp · Groupon · Facebook · Other_____

Have you ever been to a Chiropractor before? · yes · no

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** ☐

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: _____

(Please fill in selections completely)

Symptoms began on: | | | |

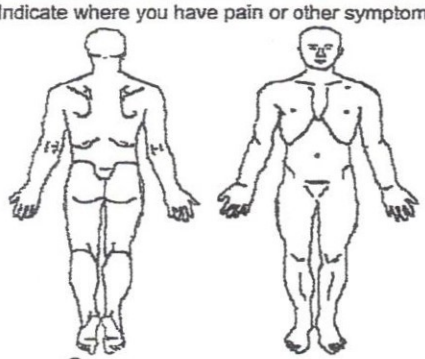
1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ **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:_____/_____/_____