Cartwright Chiropractic and Wellness Center
Healing • Restoring • Changing Lives

WELCOME TO OUR OFFICE!

Patient Information

Name: _____ Birthday: _____
Address: _____
Home Phone: _____ Cell Phone: _____
SS Number: _____ Email: _____
Employer: _____ Address: _____
Spouse's/Guardian's Name: _____ Number of Children: _____
How did you learn of this clinic? _____
Nearest relative not living with you? _____

Primary Insurance Information

Name of Insurance: _____
Address: _____
ID Number: _____
Group Number: _____
Phone Number: _____
Who is responsible for payment? SELF

Secondary Insurance Information

Name of Insurance:_____
Address: _____
ID Number: _____
Group Number: _____
Phone Number: _____
SPOUSE OTHER _____

Patient Condition

Purpose of this appointment: _____
List of your complaints: _____
Date of injury/illness: _____ Time: _____ AM PM
How did the injury occur: AUTO WORK OTHER Where did it occur: _____
What makes the condition(s) better or worse: _____
Other doctor seen for this condition: _____
Have you been treated by a doctor for any other health condition in the last year? NO YES
If yes, please describe: _____

INSURANCE INFORMATION

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

_____ _____
Signature of Patient, Parent or Legal Guardian Signature of Physician

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

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HEALTH QUESTIONNAIRE

PLEASE CHECK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Patient: _____ File Number: _____ Date: _____

MUSCULOSKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder problems

GENITO-URINARY SYSTEM

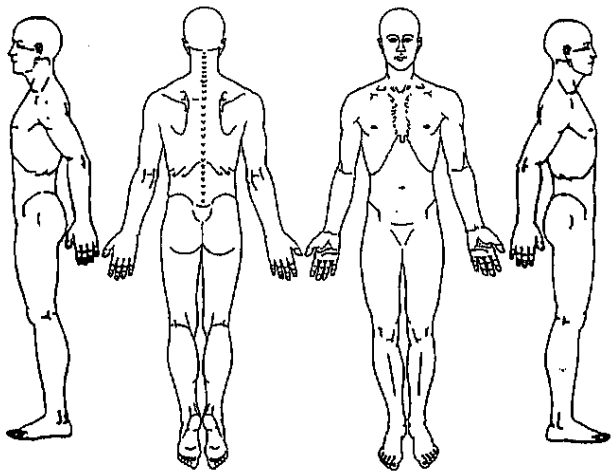
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia
(decrease of sensitivity)

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of Feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle Jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Smoking
- ❑ Alcohol use
- ❑ Coffee or tea
- ❑ Drug abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE & THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty with speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

Patient Signature _____

•••••••••••••••••••••••••••• **DO NOT WRITE BELOW THIS LINE** ••••••••••••••••••••••••••••

_____

_____

_____

Patient Accepted? YES NO Doctor's Signature _____D.C., C.C.S.P., F.I.A.M.A

CONSENT, ASSIGNMENT, AND AGREEMENT

Before we will begin any health care operations we 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 (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. I certify that all the information given in the Health Questionnaire and Health Analysis is true and correct to the best of my knowledge. I give my consent to Cartwright Chiropractic Inc. to render treatments to myself/my child as deemed necessary by the attending physician. I understand that I have the right to refuse services at any time, and will be informed of any changes in treatment prior to their performance. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

2. I understand that I am fully responsible for the payment of all services rendered. I agree to pay the amount billed for all services rendered, and agree to turn over all injury checks received by me for the services provided by Cartwright Chiropractic. I further understand that health and accident insurance policies are an arrangement between myself and the carrier, and that I may be required to pay some or all of the fees charged to my account. I hereby assign benefits to be paid directly to this provider by my third-party payer (i.e. insurance company, attorney, etc.). I agree and understand that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contact between myself and Cartwright Chiropractic Inc. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care.

3. I give my consent to Cartwright Chiropractic Inc. to perform x-rays as deemed necessary by the attending physician. I declare that, to the best of my knowledge, I am not pregnant/my child is not pregnant nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken, that they will be referred to DIAGNOSTIC IMAGING CONSULTANTS for second opinion or further interpretation and give consent for their release. I understand that there will be a fee for this service of $40.

4. I authorize Cartwright Chiropractic Inc. to send me a monthly newsletter, e-mail, and any other mail-outs they see pertinent to me.

5. The patient has the right to examine and obtain a copy of his or her own health record 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 not obligated to agree to those restrictions.

6. The patient may provide a written request to revoke consent at any time during care. This would not affect 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 that request has been presented.

7. 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. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician 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.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print or Type Patient Name

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INSURANCE VERIFICATION FORM

Patient's Name: _____

Date of Birth: _____ Today's Date: _____

Insurance Company Name: _____

Insurance Plan Type (HSA, HMO, etc): _____

Insurance Company Telephone Number: _____

Insurance Address where claims should be sent:

_____

Policy holder's employer: _____ ID# _____

Group # (if applicable to your policy): _____

Obtain and verify the following information as your claim cannot be processed without it. You will be set up as a cash patient if you have not verified your insurance coverage.

Please complete this form for each insurance you carry. Thank you!

1. Ask for the name of the person giving you the information: _____
2. Ask if you have chiropractic coverage: YES or NO
3. Ask if Dr. Rob Cartwright is in network: YES or NO
4. If you have **chiropractic coverage**, please continue to verify your coverage.
    a. What is the yearly deductible: Per Person: _____ Per Family: _____
    b. How much of the deductible has been met this year: _____
    c. What is the co-pay or co-insurance: _____
    d. How many chiropractic visits are allowed per year: _____
    e. How many physical therapy visits are allowed per year: _____
    f. Are services limited by medical necessity: _____
    g. Is wellness or maintenance care covered: _____
    h. Is advanced imaging (x-rays) covered: _____
    i. What is the effective date of the policy: _____

Thank you for obtaining and verifying this information with your insurance company.

Insurance is a contract between the insured (patient) and the insurance company. The amount and type of reimbursement varies according to the policy that has been purchased by you or your employer.

I have read, understand, and agree that I am personally responsible for all services received should my insurance fail to remit payment or should my insurance not be updated to the office which would lead to a denial in claims submitted.

_____ _____

Patient Signature Date