Patient Questionnaire – Non-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient ☐ Yes ☐ No

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

☐ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

_____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite

Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Notes: _____

_____

_____

_____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems

☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Other: _____

The Body Shop
Chiropractic and Sports Rehabilitation

219 Berlin Road ■ Cherry Hill, New Jersey 08034 ■ ph: (856) 354-0044 fax: (856) 354-1944

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I understand that if I am accepted as a patient at Body Shop Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization and Release: I understand the cost of my care with my treating doctor.
I understand that **I am responsible for payment of all deductibles and co-payments related to my care**. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check is returned for insufficient funds, I will be charged a $25.00 service charge.

I have read and fully understand the above statement and financial terms.

Patient's Signature Date

PATIENT HEALTH INFORMATION

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you them for diagnosis, assessment or treatment of your health condition

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operational purposes.

We have a policy that provides a detailed description of how your health information may be used or disclosed. You have the right to review that policy before you sign this form (164.520). We reserve the right to change our privacy practices as described in that policy. If we make a change to our privacy practices, we will notify you when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have released your health information before we received your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You may have the right to refuse this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have been offered a copy of this notice.

_____	_____
Print Name	Authorized Provider Representative
_____	_____
Signature	Location
_____	_____
Date	Date

If signed by patient's legal representative, please state representative's relationship to patient: _____

INSURANCE VERIFICATION / CASH PATIENT

Patient Name: _____ Date of Birth: _____

Billing Address: _____ SSN: _____

City: _____ Phone No.: _____

State: _____ Zip: _____ Cell Phone No.: _____

Insured Name: _____ Insured DOB: _____

Relationship to Patient: _____ Insured SSN: _____

Emergency Contact & Phone Number: _____

OFFICE USE ONLY

Provider: Travis Williams, D.C.
Provider Tax ID: 203721434
Payor ID: _____

Location: The Body Shop Chiropractic
NPI: 1538219886
Reference #: _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Date of Verification: _____ / _____ / _____ Ins. Phone #: _____

Provider in Network? ( ) Yes ( ) No Spoke To: _____

Health Spending Fund: _____ Verified By: _____

In NETWORK

Effective Date

Deduct		any met?
Copay		
COINS		

Referral Required?

Pre-Cert Required?

Limits?

Evals Covered?

Modalities Covered?

Stop Loss Amount

Out of NETWORK

Effective Date

Deduct		any met?
Copay		
COINS		

Referral Required?

Pre-Cert Required?

Limits?

Evals Covered?

Modalities Covered?

Any Met?