

Name \_\_\_\_\_

**SEAY CHIROPRACTIC & WELLNESS CENTER ~ NEW PATIENT HISTORY**

*Please fill in all spaces.*

Your Main Complaint: \_\_\_\_\_ Severity (1-10): \_\_\_\_\_ % of time: \_\_\_\_\_  
How long? \_\_\_\_\_ Date of Onset? \_\_\_\_\_ Lost workdays? YES / NO How many? \_\_\_\_\_  
When do you notice it most? AM / PM What makes the problem better? \_\_\_\_\_ Worse? \_\_\_\_\_  
Does the pain radiate? YES / NO Please specify location: \_\_\_\_\_  
Type of pain: Aching – Burning – Cramping – Dull – Throbbing – Numbness – Tingling, Other? \_\_\_\_\_  
Accident related? NO / Auto / Work Date: \_\_\_\_\_ Similar condition before? YES / NO When? \_\_\_\_\_  
Have you ever been under the care of a chiropractor? YES / NO Reason for initial visit? \_\_\_\_\_  
Do you have any Pain and/or Difficulty performing any of the following activities: (please circle all that apply)  
Personal care – Lifting – Reading – Work – Driving – Walking – Sitting – Standing – Social life – Recreation  
Is there any other injury or problem, minor or major, that the doctor should know?  
\_\_\_\_\_

**Please check all conditions you have suffered or been diagnosed with:**

(Specify Type & Right or Left side of body)

<input type="checkbox"/> *Fractured bones
<input type="checkbox"/> *Auto Accidents
<input type="checkbox"/> 0-1 yrs ago
<input type="checkbox"/> 1-5 yrs ago
<input type="checkbox"/> 5 yrs or more
<input type="checkbox"/> Other accidents, falls
<input type="checkbox"/> *Arthritis (specify type)
<input type="checkbox"/> *Diabetes
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Skin problems
<input type="checkbox"/> *Cancer (specify type)
<input type="checkbox"/> Frequent colds, flu
<input type="checkbox"/> Depressed / Irritable
<input type="checkbox"/> AIDS, HIV
<input type="checkbox"/> Anemia
<input type="checkbox"/> *Allergies to anything
<input type="checkbox"/> Convulsions, Seizures
<input type="checkbox"/> Eating disorders
<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Trouble concentrating
<input type="checkbox"/> Learning disability
<input type="checkbox"/> Mood Changes
<input type="checkbox"/> Epilepsy

<input type="checkbox"/> *Surgeries (specify below)
<input type="checkbox"/> Neck pain/stiffness R L
<input type="checkbox"/> Numbness/tingling, pain in arms, hands, fingers R L
<input type="checkbox"/> Jaw pain or clicks R L
<input type="checkbox"/> Difficulty in excessive Standing, sitting, riding, Bending, lifting, twisting
<input type="checkbox"/> Shoulder pain R L
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in ears R L
<input type="checkbox"/> Hearing loss R L
<input type="checkbox"/> Blurred or doubled vision
<input type="checkbox"/> Upper back pain, stiffness
<input type="checkbox"/> Mid back pain, stiffness
<input type="checkbox"/> Lower back pain, stiffness
<input type="checkbox"/> Pain/ blood cough/ sneeze
<input type="checkbox"/> Hip pain R L
<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness, tingling, pain in buttocks, legs, feet, toes R L
<input type="checkbox"/> *Head Trauma

<input type="checkbox"/> Foot trouble R L
<input type="checkbox"/> Chest pain, asthma
<input type="checkbox"/> Trouble breathing
<input type="checkbox"/> Heart/Circulatory problems
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Stroke ~ Date: _____
<input type="checkbox"/> High/low blood pressure
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Liver trouble
<input type="checkbox"/> Gall bladder trouble
<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Impotence
<input type="checkbox"/> Kidney trouble
<input type="checkbox"/> *Tumors / Congenital Prob.
<input type="checkbox"/> Menstrual problems (PMS)
<input type="checkbox"/> Pregnant (NOW)
<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear / Sinus Infections
<input type="checkbox"/> Alcohol or Drug addiction
<input type="checkbox"/> Smoke- How much _____

*\*Explanation~*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medication & Vitamin List

Vitamin/ Medication Name      (non) or Rx Strength      Date Began      Date Stopped      Prescribed by Dr. or Self

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## Physician List

Primary Care Physician's Name      Address      Date of last visit

Physician's Name      Specialty      Date of last visit

Physician's Name      Specialty      Date of last visit

## Pregnancy—Women Only

X-rays are contra-indicated during pregnancy. This office does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? \_\_\_\_\_

Are you currently trying to become pregnant? \_\_\_\_\_

On what date did your last period begin? \_\_\_\_\_

What method of birth control are you currently using (including partner's vasectomy, hysterectomy, or tubal ligation)?

Would you like a pregnancy test now? \_\_\_\_\_

### FOR OFFICE USE ONLY PREGNANCY TEST RESULTS

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## For Your Health

**What type of care interests you?**

**Relief Care** involves addressing the current complaint(s) to help you get out of pain.

**Corrective Care** involves addressing the current complaint(s) in addition to correcting posture and muscle imbalance through rehab and curve correction.

**Wellness Care** involves addressing the current complaint(s) in addition to correcting posture and muscle imbalance through rehab and curve correction. Wellness also involves addressing nutritional deficits, detoxification, allergies/sensitivities, emotions, & electrical pollution.

**To the best of my knowledge all information provided to Seay Chiropractic & Wellness Center is thorough and true.**

Signature \_\_\_\_\_

Date \_\_\_\_\_



# SEAY CHIROPRACTIC & WELLNESS

## ASSIGNMENT OF BENEFITS

As a courtesy, we accept insurance on assignment, upon verification of your benefits & coverage. We gladly file all claims for service, according to our policies, directly to your insurance carrier.

- You will be responsible for any/all deductibles, co-insurance/payments, and non-covered services. We will gladly provide several options to help you take care of these out of pocket expenses.
- We will do our best to accurately file your claims; however, we cannot be responsible for how your insurance chooses to reimburse for your care, even if it is different than the benefits they quoted to us.
- Should your carrier deny any claims, we will provide the necessary documents for reconsideration or for an appeal. You will be responsible for your account balance and for the pursuit of reimbursement from your insurance.
- If your care requires an authorization from your primary care doctor or insurance carrier, we will do our best to obtain these for you. It is also your responsibility to take an active role in this process. We will not assume responsibility for any unauthorized treatment.
- Most insurance plans do not cover the following: Rehabilitative, maintenance or wellness care, supports, braces, cervical pillows, supplements and most supplies. If any of the services/supplies listed above are rendered, they are required to be paid up front. We will gladly supply you with a statement to submit to your insurance carrier. We will submit all other services, but should your insurance company deem them non-covered benefit(s), you will be responsible for the full, unpaid amount submitted services.
- It is important that you inform us of ALL insurance changes. This allows us to file claims in a timely manner and prevents billing errors.
- If for **ANY** reason your insurance company does not cover a visit, you will be responsible for payment of that service. Our billing department sends monthly statements. 1 & 1/2% interest will be charged monthly on any account over 60 days. A \$25.00 "returned check fee" will be charged for all returned checks, and payment to cover that check must be paid by cash, credit card or money order.
- Neglected patient accounts are sent to a collection agency. Patients sent to the collection agency or filing for bankruptcy, causing our office to write-off any debt, are subsequently dismissed from the practice as well as all family members for whom the patient is responsible.
- **SOME INSURANCE COMPANIES TAKE SEVERAL WEEKS/MONTHS TO PAY. IF YOU DO NOT RECEIVE A BILL, IT IS BECAUSE WE ARE WAITING ON YOUR INSURANCE TO PAY. AS SOON AS ALL PAYMENTS ARE RECEIVED FROM YOUR INSURANCE COMPANY, YOU WILL RECEIVE A BILL FOR ANY PORTION THAT YOU OWE.**

With my signature below, I confirm that I have been informed and understand the above policy. I agree to be responsible for payment and to make payment arrangements if needed.

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_



## SEAY CHIROPRACTIC & WELLNESS

### **THIS NOTICE DESCRIBES TO YOU HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

#### **PLEASE REVIEW IT CAREFULLY.**

#### **UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:**

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and as a means of communication among many health care professionals who contribute to your care. It is also a legal document that describes the care you received as well as a means by which you or a third party payer can verify that services billed were actually provided. It is a tool with which we can access and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to ensure its accuracy and better understand who, what, when, where, and why others may access your health information. It also helps you make more informed decisions when authorizing disclosure to others.

#### **YOUR HEALTH INFORMATION RIGHTS:**

Although your health record is the physical property of the healthcare practitioner that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of information practices upon request, and also to inspect, and obtain, a copy of your health record. If you would like to exercise your right to a copy of your file, please call our office to schedule an appointment.

You have the right to request an accounting of disclosures of your health information and you have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

#### **OUR RESPONSIBILITIES:**

This office is required to maintain the privacy of your health insurance information and provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. The office will abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

#### **EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:**

*We will use your health information for treatment.* For example: Information obtained by our chiropractor, or any other member of our healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also disclose information from your medical record to specialists to whom you are referred in order to assist them in establishing a plan of care for you.

*We will use your health information for payment.* For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

*Business associates:* There are some services provided in our office through contacts with business associates. Examples include our use of third party billing facilities. We will disclose health information that identifies you, your

