

Marty Chiropractic  
**Patient Information**

DATE \_\_\_\_\_

DOCTOR \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ E mail \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status S M Spouse/Parent \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

May we leave messages at Home Phone YES NO May we leave messages at Work Phone? YES NO

Primary Physician \_\_\_\_\_ May we contact your physician? \_\_\_\_\_

Primary Clinic \_\_\_\_\_ Who may we thank for referring you to our office? \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

-----INSURANCE INFORMATION ----- NOT A GUARANTEE OF PAYMENT -----

**Insurance:** \_\_\_\_\_ Contact Person \_\_\_\_\_

Effective Date \_\_\_\_\_ ID / Claim \_\_\_\_\_ Acct / Group \_\_\_\_\_

Referral? Y N Deductible? \_\_\_\_\_ Co-Pay? \_\_\_\_\_ Percent Covered? \_\_\_\_\_ Prior Auth? \_\_\_\_\_

Exams? \_\_\_\_ % Therapy? \_\_\_\_ % X-Rays? \_\_\_\_ Massage? \_\_\_\_ Acupuncture \_\_\_\_ Limit No. of Visits? \_\_\_\_\_

OUT-OF-NET \_\_\_\_\_ Confirmed by \_\_\_\_\_

**AUTO W/COMP** Date of Injury \_\_\_\_\_ Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

**AGREEMENT TO PAY FOR TREATMENT:** The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors, such as massages, orthotics or supplements.

**ASSIGNMENT OF INSURANCE:** I hereby authorize and instruct the insurance company mentioned above to pay any insurance benefits otherwise payable to me under my current insurance policy directly to MARTY CHIROPRACTIC, 2424 East 117<sup>th</sup> Street, Burnsville, MN 55337, for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay any balance of said professional service charges over and above this insurance payment according to the financial policy of the above assignee, which may include interest, service fees and/or collections costs. I understand that my signature on this document may replace the need for my signature on each claim form. A photo copy of this assignment shall be considered as effective and valid as the original.

**RELEASE OF MEDICAL INFORMATION:** I also authorize the release of any information concerning my medical history, diagnosis, and treatment pertinent to my case to any insurance company, adjuster, or attorney involved in this case. THIS AUTHORIZATION AND ASSIGNMENT SHALL BE IRREVOCABLE FOR THE FULL EXTENT OF MY TREATMENT AT MARTY CHIROPRACTIC CLINIC AND UNTIL SUCH TIME THAT ANY AND ALL EXPENSES INCURRED HAVE BEEN PAID IN FULL.

**I UNDERSTAND** that I am authorizing Marty Chiropractic to proceed with any treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

**PERMISSION TO TREAT MINOR:** I hereby authorize the doctors and staff of Marty Chiropractic to examine, X-ray and treat \_\_\_\_\_ (name of patient).

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ChiroCare Form PHQ-202

ChiroCare Use Only rev 5/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

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

a. When did your symptoms start?

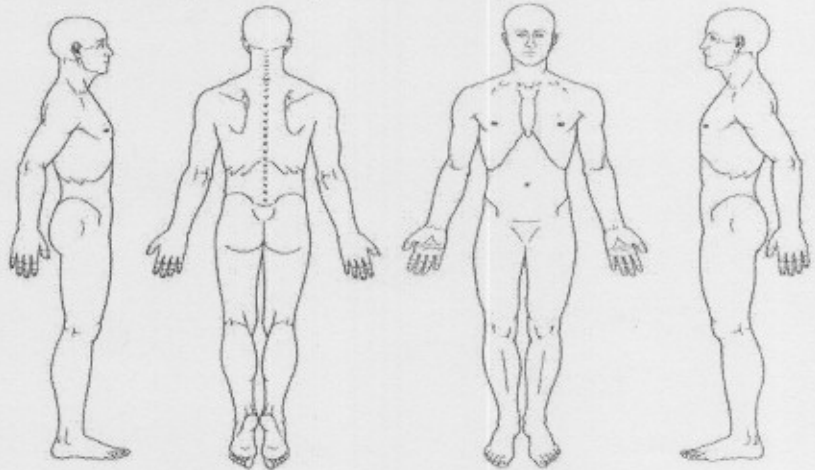
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

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



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

b. How much has pain interfered with your normal work (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. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time      ② Most of the time      ③ Some of the time      ④ A little of the time      ⑤ None of the time

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

- ① Excellent      ② Very Good      ③ Good      ④ Fair      ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One      ② Other Chiropractor      ③ Medical Doctor      ④ Physical Therapist      ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_      ③ CT Scan date: \_\_\_\_\_  
② MRI date: \_\_\_\_\_      ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes      ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office      ② Other Chiropractor      ③ Medical Doctor      ④ Physical Therapist      ⑤ Other

## 10. What is your occupation?

- ① Professional/Executive      ② White Collar/Secretarial      ③ Tradesperson      ④ Laborer      ⑤ Homemaker      ⑥ FT Student      ⑦ Retired      ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time      ② Part-time      ③ Self-employed      ④ Unemployed      ⑤ Off work      ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must 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 we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records 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 his/her PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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 the request has been presented.
5. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, than this clinic will not treat/admit you.

I have read this form and understand how my Patient Health Information will be used. I agree to these policies and procedures.

Print your name here: \_\_\_\_\_

Sign your name here: \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Marty Chiropractic to send to my e-mail address, \_\_\_\_\_ periodic health-related educational material. I understand that this address will not be sold to any marketing companies for solicitation purposes.

Sign your name here: \_\_\_\_\_ Date \_\_\_\_\_