Date:_____

Blackmon Chiropractic Clinic, P.A
7000 Cantrell Road
Little Rock, AR 72207
(501)-663-4101

New Patient Health Form

Patient Name:_____ Date Of Birth:_____Age:_____

Address:_____City:_____State:_____ Zip:_____

Cell Phone:_____ Email:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone Number:_____

Spouses Name:_____ Who Referred you:_____

Are you taking any medication?

(Please list dosage, frequency, amounts,etc)

• **What medications are you taking?** • **What vitamins, minerals, or herbs do you currently take?**	**Reason for taking medication:**

TELL US ABOUT YOUR PROBLEM

Name: _____ Date: _____

1. What's your major symptom? _____

2. When did the first symptoms start? _____

3. Does it radiate into any of the extremities (Arms or Legs)? ____ Yes ____ No

If yes, please describe: _____

4. How did it originally occur? _____

_____

5. Is it getting ____ Better ____ Worse ___ Staying the same

6. How frequent is the condition? _____Constant _____Comes and Goes

7. Describe the pain: ___Sharp ___Dull ___ Numbness ___Tingling ___ Aching ___ Burning ___Stabbing

Other _____

8. Are there any other symptoms or problems related to your major symptom? ___ Yes ___ No

If yes, please describe: _____

9. Is there anything you can do to relieve the problem? ___ Yes ___ No

If yes, please describe: _____

10. What makes the problem worse? ___Standing ___Sitting ___Lying ___Bending ___Lifting ___Twisting

Other: _____

11. Have you ever had the same or similar condition in the past? ___ Yes ___No

If yes, please describe and dates: _____

12. Have you had an MRI or C.T. Scan in the last 5 years? ___Yes ___ No

If yes, please list approximate date and location: _____

Answer questions below and if answered yes please briefly explain:

Been hospitalized? (last 5 years)	○ Yes ○ No	
Auto accident? (last 5 years)	○ Yes ○ No	
Any previous surgeries?	○ Yes ○ No	

FUNCTIONAL RATING INDEX

To properly assess your condition, we must understand how much your spinal problem has affected your ability to manage everyday activities.

For each time below, please circle the number which most closely describes your current condition.

Pain Intensity:

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____10 _____
None. Mild Uncomfortable Distressing Intense Unbearable

Frequency of Pain:

1 _____ 2 _____ 3_____ 4 _____
25% 50% 75% 100%

Traveling:

1 _____ 2 _____ 3_____ 4 _____
No pain Mild Pain Moderate Pain Severe Pain

Work:

1 _____ 2 _____ 3_____ 4 _____
Can do usual work | Can do 50% of work | Can do 25% of work | Cannot Work

Recreation:

1 _____ 2 _____ 3_____ 4 _____
Can do all activities | Can do most activities | Can do few activities | Cannot do any activities

Lifting:

1 _____ 2 _____ 3_____ 4 _____
No pain with lifting | Increased pain with lightweight | Increased pain with moderate weight | Increased pain with heavy weight

Sleeping:

1 _____ 2 _____ 3_____ 4 _____
No problem Mildly disturbed Moderately disturbed Totally disturbed

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements.

Name: _____ Date: _____

Family Medical History *(Record on diagnosis in your family history and the affected)*

Diagnosis:	Father:	Mother:	Sibling:	Offspring:

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name:	Dosage & Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name:	Reaction:	Onset Date:	Additional Comments:

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front desk staff or supervisor.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, and credit cards. Outside financing is available upon request and approval.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. Our office does not guarantee that your insurance will pay. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay this practice within a reasonable period of time, we will have to look to you for payment.

We have made prior arrangements with certain insurers and other health plans to accept assignments of benefits. We will bill those planes with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be “not covered” or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collections fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.

There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

Just to reiterate, our office does not guarantee that your insurance will pay. If for some reason your insurance claim is denied, you are responsible for the full amount of your bill.

Patient Name - Please Print: _____

Patient Signature: _____ Date: _____

Blackmon Chiropractic Clinic
Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____ Date: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this _____ day of _____, 20_____

By _____
Patient's Signature

If Patient is a minor or under a guardianship order as defined by state law:

By _____
Signature of Parent / Guardian (circle one)

Permission to Release Information to Other Parties

Anyone other than the Doctors involved in your care (Example: family members, friends)

I, _____hereby authorize Blackmon Chiropractic Clinic to use or disclose my Protected Health Information (PHI) in the following manner.

To: _____

This authorization is in full force and effect until notified of change.

I understand that I have the right to revoke this authorization in writing by sending notification to Blackmon Chiropractic Clinic at 7000 Cantrell Rd, Little Rock, AR 72207

Blackmon Chiropractic Clinic Informed Consent

Nature and purpose of chiropractic procedures:

The practice of Chiropractic includes many standard examinations and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, laboratory tests, radiology examination, physical therapy, and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession- the chiropractic spinal adjustment, sometimes referred to as spinal manipulation.

Spinal adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxations. This condition exists when one or more vertebrae in the spine are misaligned sufficiently to cause irritation or interference of the nervous system. The primary goal in chiropractic health is the removal of nerve interference caused by such subluxations.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments may be performed by hand or hand guide instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of vertebra.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of inherent risk and limitations. These are seldom enough to not contradict care but should be considered in making the decision to receive chiropractic care. All health care procedures have some risk associated with some chiropractic adjusting procedures, while extremely rare, may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndromes (VAS), including stroke and perhaps death through complicating factors.

Authorization for Chiropractic Care:

I have been informed of the nature and purpose of Chiropractic Care, the possible consequences, and the risk of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences, if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE BLACKMAN CHIROPRACTIC CLINIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____	_____	_____
Patient Name - Please Print	Patient's Signature	Date

When patient is a minor or unable to consent:

Patient's Name: _____ Patient's Age: _____

Person Authorized To Sign: _____ Relationship: _____
Please Print

Signature of authorized person: _____

PREGNANCY RELEASE: INFORMED CONSENT TO X RAY

All women of childbearing age must sign this release and check the appropriate category.

"This is to clarify that, to the best of my knowledge, I am not pregnant. Blackmon Chiropractic Clinic has my permission to take X-Rays. I will Assume all responsibility for any effect on a fetus potentially present."

_____ I am within the first 10 days AFTER the onset of my menstrual cycle.

Date of Onset: _____

_____ I am currently using a form of birth control.

_____ I have had a hysterectomy or tubal ligation.

_____ I am presently in menopause or post menopause.

_____ Other (Please Specify) _____

Patient Signature: _____ Date: _____