Bailey Chiropractic

11279 Perry Highway, Wexford, PA 15090
724 – 934 – 0899

HISTORY UPDATE FORM

Please present your insurance card(s) so we can put a copy in your file.

Date Patient #

☐Mr. ☐Mrs. ☐ Ms. _____
(First) (Initial) (Last) (Nickname)

Address _____

Phone #_____ Cell # _____ Email_____

City_____ State_____ Zip_____ Birthday_____ Age:_____ ☐ Male ☐ Female

Employer _____Occupation _____

Address _____ City_____ State_____ Zip_____

Insurance Company_____

Is patient covered by **Spouse's** insurance? ☐ No ☐ Yes Is patient covered by additional insurance? ☐ No ☐ Yes

Subscriber Name _____ Birthday_____
(First) (Initial) (Last)

Employer_____ Insurance Company_____

Please present insurance card(s) so we can put a copy in your file.

Present complaints include:_____

_____

Have you suffered any new trauma since last seen in this office? ☐Yes ☐ No If yes, please give details

_____

_____

Present medications_____

Have you had any surgery in the past two years or since your list visit? ☐Yes ☐ No If yes, please list –

Surgery _____ Date_____

Surgery_____ Date_____

Do you have any questions regarding your insurance or charges for services in this office? _____

_____

Additional Information:_____

_____

Signature_____ Date_____

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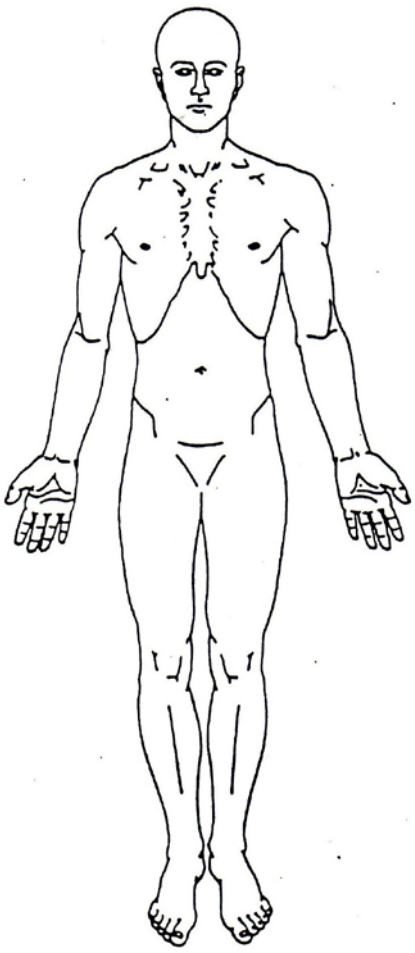
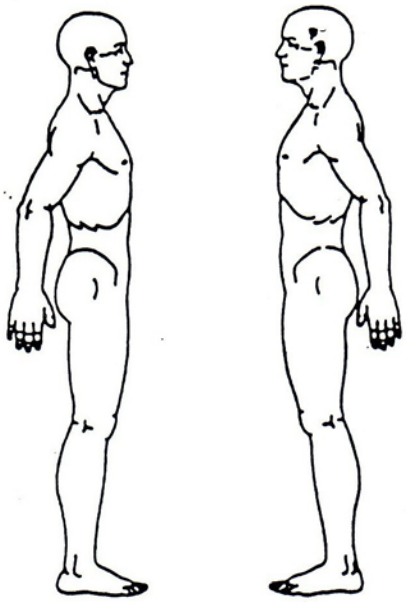
DIAGRAM OF PATIENT'S DISCOMFORT

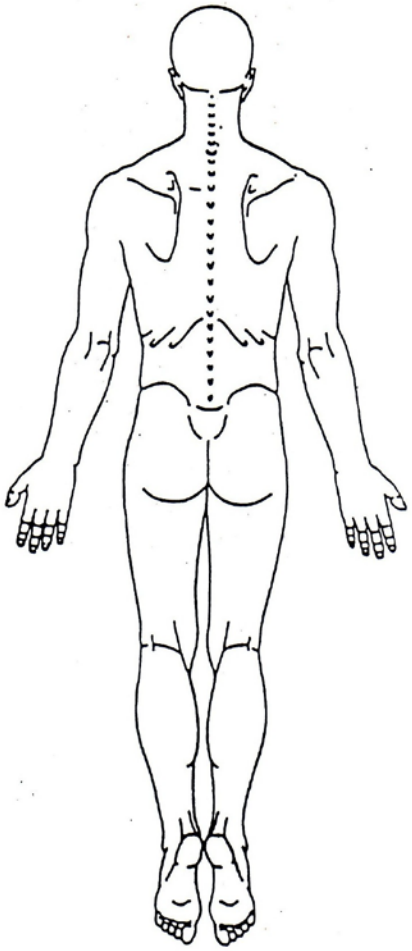
Name		Date
Habits		
☐ Smoke - packs /day	☐ Coffee - Cups/day	☐Alcohol - Amount/day
Exercise		
☐ None ☐ Moderate ☐ Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		☐ Yes ☐ No
☐ Over the counter	☐ From my doctor	☐ I send away for them
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)										
1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Use these figures to mark your pain







Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other

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9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

☐ HOME TELEPHONE: _____

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

OR

☐ N0, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.

☐ If necessary may we call you at work? If yes, list number_____

Signature of patient_____ Date _____/____/_____
or legal proxy

Office Policy – Insurance Assignment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I understand that the Doctor's Office 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 the Doctor's Office will be credited to my account on receipt.

This office DOES NOT promise that an insurance company will pay, nor does the office promise that an insurance company will or should pay the fees as charged

The office will not enter into a dispute with an insurance company over reimbursements or the amount of reimbursement. This is the patient's obligation.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

The patient also agrees that he/she is responsible for all bills incurred at this office

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.All deductible amounts must be paid prior to insurance submittals

The patient must stay current with their percentage of responsibility (e.g. insurance pays 80% of the bill, and the patient pays 20%). Bills must be paid each visit unless other arrangements have been made.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

If the patient discontinues care for any reason other than discharge by the doctor-the bill is due and payable in full-immediately, regardless of any claims submitted.

If patient fails to keep regular appointments they will be discharged. The bill is then due and payable in full-immediately.

If I fail to keep an appointment I maybe charged a no show fee of $10.00 per missed appointment.

It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I hereby authorize the Doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

THERE CAN BE NO EXCEPTIONS TO THE ABOVE WE ARE ONLY TOO HAPPY TO ANSWER QUESTIONS YOU MAY HAVE.

Patient Signature_____ Date _____/_____/_____