JACKSON CHIROPRAC IC

"The Power that Made the Body Heals the Body"

Today's Date

Pt File#

Tell Us About Yourself

Patient Name: _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ (Permission to call or text appointment reminder's is given upon entering phone numbers)
(Check here if you want to opt out of automated call or text reminders) ☐

Email Address: _____

Place of Employment: _____ Work Phone: _____

Birth Date: ____/____/____ Height: ____ft ____in Weight: _____ lbs ☐ Male ☐ Female

Please indicate the best way to contact you: _____

Name of Your M.D./D.O.: _____ Date of last visit:____/____/____

In Case of Emergency Please Notify: _____ Phone #: _____

Please Circle Only One of ALL the Following:

Single Married Widowed Divorced Number of Children: _____

Race: American Indian Alaska Native Asian White Black or African American
Native Hawaiian Other Pacific Islander Declined to State

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to State

Did Someone refer you?: _____

HABITS:

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker

☐ Drinking Alcohol (cups/day: _____ ☐ Coffee (cups/day): _____

☐ Soft Drink Bottles/Cans/day: _____ ☐ Water (cups/day): _____

EXERCISE

☐ None
☐ Moderate
☐ Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐

Are you taking any medication (prescription or over the counter)? ☐ YES ☐ NO

If **YES**, please indicate the following:

Medication: _____ mg/mcg_____
Route: Oral, Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Medication: _____ mg/mcg_____
Route: Oral, Intravenous
Other: _____
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Medication: _____ mg/mcg_____
Route: Oral, Intravenous
Other: _____
Frequency: _____
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Discontinued Use: _____

Medication: _____ mg/mcg_____
Route: Oral, Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Use back if more space for medication is needed

Have you taken Medications in the past, Yes ☐ No ☐ If YES which ones: _____

List of Over the Counter Medications Etc: _____

_____

Do you have allergies to medication? Yes ☐ No☐

If **YES** please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Use back if more space for allergies is needed

Have you had any Surgeries? Yes ☐ No ☐

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

OTHER: _____

DATE/DATES:_____

JACKSON CHIROPRAC IC

3330 Cameron Park Drive Ste 200
Cameron Park, CA 95862
(530) 621-4803

Chief Complaint: _____

PLEASE COMPLETE: SYMPTOMS BEGAN ON: | | | |

(Please fill in sections completely)

1. Briefly describe your symptoms: _____

2. How did your symptoms start?: _____

3. Average Pain Intensity: (Place an X in the boxes that apply)

Last 24 Hours:	0	1	2	3	4	5	6	7	8	9	**10** worst pain
Past Week:	0	1	2	3	4	5	6	7	8	9	**10** worst pain

4. How often do you experience your symptoms: (Place an X in the box that applies)

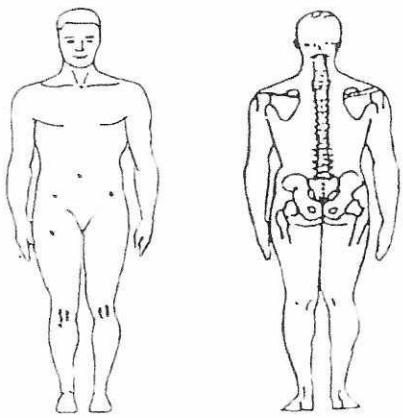
☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time)

☐ Occasionally (26%-50% of the time) ☐ Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work and home)
(Place an X in the box that applies)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

PLEASE INDICATE BELOW BY PLACING AN X OR CIRCLE ON ALL YOUR CURRENT PROBLEM AREAS:



_____ _____

Patient Signature **Date:**

Tell Us about the Insured Person

I am the insured person: ☐

Insured's Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Cell Phone: _____

Primary Insurance Company:

Name: _____

ID Number: _____ Deductible: $_____ Co-Pay Amount: $_____

Group Number: _____ Effective Date: _____

Employer Name: _____ Employer Address: _____

Secondary Insurance Company:

I am the insured person: ☐

Name: _____

ID Number: _____ Deductible: $ _____ Co-Pay Amount:$ _____

Group Number:_____ Effective 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 well begin any health care operations we must require you to read and sign this consent form stating that you understand and agree.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, healthcare operations, and coordination of care. Be assured this office will limit the release of all PHI to the minimum needed.
2. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their 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 to 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. Patients have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.

I have read and understand how my Patient Health Information will be used, and what my Financial Responsibility is, and by signing below I agree to these policies and procedures.

***Signature:** _____ **Date:** _____

JACKSON CHIROPRAC IC

Dr. G. Keith Jackson, D.C./Applied Kinesiologist, Nutrition Expert
3330 Cameron Park Drive Ste 200, Cameron Park, Ca 95682 (530) 621-4803

FINANCIAL POLICY

Welcome to our office! We assure you that you will be receiving the very *Best Chiropractic* care available. The following policies will explain how Chiropractic billing will be handled:

It is our policy to maintain your account on a current basis. *Charges for treatment are due at the time of service, including deductibles, and co-pays.*

If you are unable to make the complete payment at the time of treatment we do have payment plans available. If we enter into a payment plan with you we ask that you make your payments on a timely basis. Payments are due the 10th of each month and will be considered late on the 15th. A service charge of 1.5% monthly may be applied.

If you have insurance, we will gladly submit claims on your behalf for our reimbursement, however you are the responsible party so please remember that this is a courtesy to you and your insurance coverage is a contract between you and your insurance company, and payment for chiropractic treatment is not contingent on reimbursements from your insurance company. We reserve the right to collect any services deemed "NON-Covered" either by our office and/or by your insurance company. It is impossible for us to know your exact policy or to know when changes occur that may affect reimbursement, therefore ANY AND ALL BALANCES WILL REMAIN YOUR RESPONSIBILITY which may include NON-Covered Services.

Please Initial You have Read and understand the above Paragraph: _____

Monthly service charges of 1.5% may be added to balances due and not paid within 30 days, and any associated legal fees and collection fees (up to 30%) will be your responsibility if necessary.

If you have any questions concerning our financial policies, please ask the Office Manager Kathy for clarification. *Once again, we welcome you to Jackson Chiropractic, Inc.*

PLEASE INDICATE THE PREFERRED METHOD OF PAYMENT:

[ ] CASH/CHECK [ ] CHARGE [ ] WORKMEN'S COMPENSATION

[ ] AUTOMOBILE MEDICAL PAYMENTS [ ] INSURANCE

(Name of Company): _____

[ ] I HAVE HIRED AN ATTORNEY (His/Her Name): _____

Address: _____ Phone #: _____

I have read and understand the above policies, and by signing below, agree to all of the terms as stated.

_____ _____

Signature Date