Patient Information

Patient Name: _____ Date: _____

Address: _____
(Street) (City) (State) (Zip)

Phone: _____ Cell: _____ Work:_____

Sex: M F DOB: _____ Age:_____ Marital Status: S M D W

Patient SS#: _____ Email: _____

Employer: _____ Occupation:_____

Spouse's Name: _____ SS#_____ DOB:_____

Employer: _____ Occupation: _____ Phone:_____

Whom may we thank for referring you? _____

Please check how you would like to receive a appointment reminder: _____E-mail ____Text message

Who is you cell phone carrier: _____

In case of emergency contact information

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder (2nd): _____

DOB: _____ DOB (2nd): _____

Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Lee W. Hodge all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may us my health care information and may disclose such information to the above named Insurance Company(is) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____ _____
(Sign Name) (Print Name) (Date)

Abundant Health Chiropractic/Lee W. Hodge, D.C.
797 Teal Dr., Conway, AR 72034
(501) 329-2774

Account#:_____

Patient Condition

Reason for visit: _____

Is this condition due to an accident: ☐ Yes ☐ No Date of accident: _____

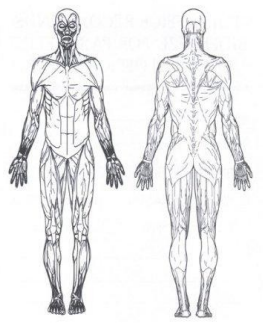
Type of accident: ☐Auto ☐Work ☐Home ☐Other

When did symptoms appear: _____

Is this condition getting progressively worse: ☐Yes ☐No

Is this pain constant or does it come and go: _____

Mark X on the picture where you continue to have pain, numbness, or tingling:→



Type of pain:

☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting

☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other:_____

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain): _____

Does it interfere with your: ☐Work ☐ Sleep ☐Daily Routine ☐Recreation

EXERCISE	WORK	ACTIVITY/FREQUENCY
☐None	☐Sitting	Smoking _____Packs/Day
☐ Moderate	☐Standing	Alcohol _____Drinks/Week
☐Daily	☐Light Labor	Caffeine Drinks _____ Daily
☐Heavy	☐Heavy Labor	High Stress Level-Reason _____

Patient Initials: _____

Women Only-Pregnancy Release:

Are you pregnant: ☐Yes ☐No Due Date: _____

Date of last menstrual period: _____

This is to certify that to the best of my knowledge I am not pregnant, and the doctor and his associates have my permission to perform an X-Ray evaluation if needed. I have been advised that X-Rays can be hazardous to an unborn child.

_____ _____

(Signature) **(Date)**

Abundant Health Chiropractic/Lee W. Hodge, D.C.
797 Teal Dr., Conway, AR 72034
(501) 329-2774

Account#:_____

Health History

Please check to indicate if you have had any of the following:

☐AIDS/HIV	☐Diabetes	☐Measles	☐Scarlet Fever
☐Alcoholism	☐Emphysema	☐Migraines	☐Stroke
☐Anemia	☐Epilepsy	☐Miscarriage	☐Suicide Attempt
☐Anorexia	☐Fractures	☐Mononucleosis	☐Thyroid Problems
☐Appendicitis	☐Glaucoma	☐Multiple Sclerosis	☐Tonsillitis
☐Arthritis	☐Goiter	☐Mumps	☐Tuberculosis
☐Asthma	☐Gonorrhea	☐Osteoporosis	☐Tumors, Growths
☐Bleeding Disorders	☐Gout	☐Pacemaker	☐Typhoid Fever
☐Breast Lump	☐Heart Disease	☐Pneumonia	☐Ulcers
☐Bronchitis	☐Hepatitis	☐Polio	☐Vaginal Infections
☐Bulimia	☐Hernia	☐Prostate Problems	☐Venereal Disease
☐Cancer	☐Herpes	☐Prosthesis	☐Whooping Cough
☐Cataracts	☐High Cholesterol	☐Psychiatric Care	☐Other_____
☐Chemical Dependency	☐Kidney Disease	☐Rheumatism	_____
☐Chicken Pox	☐Liver Disease	☐Rheumatic Fever	

What treatment have you already received for your condition?

☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Care **(Doctor Name):**_____

☐None ☐Other_____

Name(s) of other doctor(s) who have treated you for this condition _____

_____

Dates of last:

Physical Exam: _____ Spinal Exam/Adjustment: _____

Spinal X-Ray: _____ MRI:_____

CT: _____ Bone Scan: _____

Injuries/Surgeries	**Date**
Falls:_____	_____
Head Injuries:_____	_____
Broken Bones:_____Dislocations:_____	_____
Surgeries:_____	_____

Medications: _____ Allergies: _____

Vitamins/Herbs/Minerals:_____

Patient Initials: _____ **Account# _____**

Abundant Health Chiropractic/Lee W. Hodge, D.C.
797 Teal Dr., Conway, AR 72034
(501) 329-2774

ABUNDANT HEALTH CHIROPRACTIC

THIS NOTICE DESCRIBES HOW CHIROPRACTIC & MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient of Abundant Health Chiropractic we may use or disclose personal health related information about you in the following ways:

~Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.

~Your health care records as well as you billing records may be disclosed to another party such as an insurance carrier, an HMO, a PPO, or your employer if they are or may be responsible for the payment of your services.

~Your name, address, phone number, & your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to refuse to provide authorization for this office to contact you regarding these matters. If your do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, *we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

~If we are providing health care services to you based on the orders of another health care provider.

~If we provide health care services to you in an emergency. If we are required by law to provide care to you & we are unable to obtain your consent after attempting to do so.

~If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or the status of your account. If you would like the information in a different form please advise us in writing as to your preference. You have the right to inspect and/or copy of your health information for **7 years** from the date that the record was created or as long as the information remains on file**(copy fee may apply).** In addition you have the right to request an amendment to your health information. Request to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by state and federal law*to maintain the privacy of your patient file & the health-protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing. Any changes in our privacy notice will apply for all of your information in our files. Information that we use/disclosed based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information & may no longer be protected by the federal privacy rules. Please direct any questions/complaints regarding this policy to **Lee W. Hodge, D.C. of Abundant Health Chiropractic, 797 Teal Drive, Conway, AR 72034 (501) 329-2774.**

This notice is effective as of **April 7, 2003** & will expire 7 years from the date signed. My signature acknowledges that I have received a copy of this notice.

***Health Insurance Portability & Accountability Act (Civil Rights 1996)**

_____	_____	_____
Name (print)	**Signature**	**Date**

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative	**Signature**	**Date**

FINANCIAL POLICY

In this agreement the words **"you," "your," & "yours"** mean the **Patient/Debtor**. The word **"account"** means the account that has been established in your name to which charges are made & payments credited. The words **"we", "us," & "our"** refer to **Lee W. Hodge, D.C.** By executing this agreement, you are agreeing to pay for all services that are received. Once you have signed this agreement, you agree to all of the terms & conditions contained herein & the agreement will be in full force & effect.

Insurance: Insurance is a contract between you & your insurance company. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination. If your insurance company requires a referral &/or authorization, you are responsible for obtaining it. Your deductible, co-insurance, or co-pay is due when services are rendered, we will not bill you for this. When this office is contracted with your insurance company we are required by your insurance company to submit all the services rendered to you. Your insurance company will inform us the amount of your coinsurance/co-payment &/or deductible. **Some insurance will not cover our Electric Stim, Ultrasound, or Micro-Light Lazer therapy. The fee for each therapy is $10.00.**

Medicare Patients: Medicare insurance will not cover any exams, consultations, therapy, or x-ray charges. Medicare secondary will not cover any charges that Medicare will not cover. A exam/consultation is done on your first visit, the fee for these services is **$30.00** & is due on the date of service. When X-Rays are needed a fee of **$50 - $150.00** will be charged to the patient & is due on the date of service. Each year we are required by Medicare to perform a re-exam or X-Rays. The re-exam fee is **$30.00** & the X-Ray fee is **$50 - $150.00** & is due on the date of service. **Electric Stim, Ultrasound, or Micro-Light Lazer therapy fee is $10.00 for each service.**

Fees if you have no insurance: Our first time fee **($70.00)** includes an exam, consult, & adjustment. X-Rays are **$50 - $150.00** if needed. On your next visit the fee for your adjustment is **$40.00 & $10.00 per therapy**. 14 yrs. old & under the fee is **$25.00 & $10.00 per therapy**. An exam/consultation is charged **($30.00 fee)** when a patient hasn't been seen in **1 year** from the last date of service. Payment is due the day services are received.

Past Due Accts: When your account does become delinquent we do reserve the right to charge you a late fee and/or a re-billing fee. The fee for a account **30 days** past due is **$5.00 per month**. Our re-billing fee per month is **$2.00**. A returned check fee is **$25.00**. After the **3rd** statement sent the account will be sent to an outside collection firm, you agree to pay **ALL** of the collection/court cost. When an account is referred to a lawyer or small claims court, you agree to pay **ALL** fees that may incur.

Personal Injury/Auto Accident: When you are being treated as part of a personal injury lawsuit/claim, we require verification from your attorney/insurance company prior to your initial visit. Your account must be settled within **TWO YEARS** of the first date of service or the account will be turned over to collections/small claims court. Also, a medical lien will be filed with the court to insure us payment from your attorney or insurance company. All charges **(attorney fees & court costs)** for a medical lien will be added to your balance.

Waiver or Confidentiality: You understand if this account is submitted to an attorney/collection agency, if we have to litigate in court, or if your account is reported to a credit reporting agency, the fact that you received treatment in our office may become a matter of public record.

Signature: _____ Date: _____

Co-Signature(under 18 yrs. old): _____ Date: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Spinal Adjustment: A spinal adjustment is the specific application of forces to facilitate the body's correction of vertebral sublaxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral sublaxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis

_____ _____
(Signature) **(Date)**

Consent for a minor child to receive a evaluation and spinal adjustment

I _____ being a parent or legal guardian of
(Print Name)

_____ have read and fully understand the above terms of
(Print Child's Name)

acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Gaurdian Signature) **(Date)**