**Family Chiropractic Center of Santa Fe**
**2019 Galisteo St. Suite M6 Santa Fe, NM 87505**
**505-984-0006 www.spchiro.net**

# PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin

☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye

☐ Other: _____

List any **Surgeries** with dates:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

☐ Other: _____

_____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain

☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting

☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems

☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain

☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis

☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate Problems

☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Stroke/Heart Attack

☐ Other: _____

List **Medications** you are taking:

_____

_____

_____

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy

☐ Genetic Spinal Condition ☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis

☐ Neurological Problems ☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Stroke/Heart Attack

☐ Other: _____

Have you ever been in a car accident? ☐ Yes ☐ No

Have you ever had any minor injuries? ☐ Yes ☐ No

Have you ever had any major injuries? ☐ Yes ☐ No

Date of last physical examination: _____ Do you smoke? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No (what forms and how often): _____

What is your major complaint? _____

_____

_____

How did this problem begin (falling, lifting, etc.)? _____

_____

_____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐ YES ☐ NO What happened? _____

_____

How often do you experience your symptoms? Please describe in detail: _____

_____

_____

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling

☐ Radiating Pain ☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your average pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving? Please rate on a scale of 0 to 10 (0= no pain and 10= excruciating pain) _____

What activities aggravate your condition (working, exercise, etc)? _____

_____

_____

What makes your pain better (ice, heat, massage, etc)? _____

_____

_____

Do you have a secondary complaint? _____

How and when did this problem begin (falling, lifting, etc.)? _____

_____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐ YES ☐ NO What happened? _____

_____

How often do you experience your symptoms? Please describe in detail _____

_____

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling

☐ Radiating Pain ☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) _____

How do your symptoms affect your ability to perform daily activities such as working or driving? Please rate on a scale of 0 to 10 (0= no pain and 10= excruciating pain) _____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

**How did you find us?** _____

I authorize this office to release any information necessary to expedite insurance claims.

I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian printed name as signature

**/s/**_____ Date _____

Have you ever had chiropractic care? _____

When and where? _____

Why? _____

When was your last treatment? _____

# PATIENT'S REPORT OF ACCIDENT

Name _____ Date _____

Location of Accident _____

Date of Accident _____ Time _____ Was a police report made? _____

Were you the: ☐ Driver ☐ Passenger Were you wearing a seatbelt? _____

Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Speed of your car ____ Speed of other car _____ Your car type _____

Other car type _____ _____ Approximate damages you $ _____ them $_____

How did this accident occur? _____

_____

_____

_____

_____

_____

_____

How did you feel right after impact? _____

_____

How have you felt since the accident? _____

_____

Have you received treatment for this accident/where? _____

_____

Have you been off work because of this accident? _____ For how long? _____

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# FINANCIAL POLICY OF THE FAMILY CHIROPRACTIC CENTER OF SANTA FE

Thank you for choosing us as your health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment.

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**PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE**

The following is a statement of our Financial Policy which we require that you read and sign prior to treatment.

## *REGARDING INSURANCE*

We will accept assignment of benefits from an insurance policy that is in force at the time of treatment and that covers the treatment provided by this office. You will be responsible for payment at the time of visit for what has been determined to be your portion of the bill. We cannot bill your insurance company unless you provide us with all insurance information. Please understand that your insurance policy is a contract between you and your insurance company. Please be aware that some or perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your policy. We will do our best to verify and determine your coverage benefits so that you will know in advance just what is covered. The bottom line is that you are ultimately responsible for payment of all charges incurred by you at this office. In the case of managed care plans, we will accept the contracted amounts and you will be responsible for your co-payments or co-insurance amounts. You will not be charged the difference between our usual and customary rates and the contracted rates set by the managed care plans. **We accept assignment for Medicare claims and will bill them for payment. Your only charge will be for the initial exam and to meet your deductible and any co-insurance or copay, if applicable.**

## *PERSONAL INJURY POLICY*

If you have been injured in an auto accident, we will look first to the MedPay part of ***your*** auto insurance to pay for services, regardless of who was at fault. If you do not have that coverage, or if you've been injured in another type of accident, you will either pay for services as they are incurred or contract with a personal injury attorney who will provide us with a Letter of Protection, stating that we will be paid by that attorney after settlement of your case. All fees incurred for treatment at this office will be due and payable following settlement. You will be ultimately responsible for payment of all treatment costs if the attorney fails to do so.

## *MISSED MASSAGE THERAPY APPOINTMENTS*

**Unless canceled 24 hours in advance, our policy is to charge the entire amount due for the massage appointment at the rate of $40.00 per half hour**. You will not be charged if an emergency prevents you from keeping your appointment. An emergency is defined as***… "a sudden, urgent, usually unexpected occurrence requiring immediate action".*** Using our voice mail or email will enable you to leave a message when our office is closed.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions.

**I have read the above Financial Policy. I understand and agree to this Financial Policy**.

**/s/**_____ _____
Patient Printed Name as Signature Date

**/s/**_____ _____
Guardian/Responsible Party Printed Name as Signature Date

**To Stephen Perlstein, DC/Family Chiropractic Center of Santa Fe,**
**in consideration of your undertaking to treat me, I agree to the following:**

## *AUTHORIZATION AND ASSIGNMENT FOR INSURANCE*

You are authorized to release any information you deem appropriate concerning my physical condition to my insurance company in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I also authorize my insurance company to direct payment of these charges to you as per my policy agreements.

DATED: _____ PATIENT: ***/s/***_____
Printed name as signature

## *ACKNOWLEDGMENT AND UNDERSTANDING FOR INSURANCE*

I hereby acknowledge that I am ultimately responsible for payment of any charges incurred by me at the Family Chiropractic Center of Santa Fe. If my insurance company refuses to pay for charges and/or services for which reimbursement is anticipated, I will pay these charges immediately upon notification.

DATED: _____ PATIENT: ***/s/***_____
Printed name as signature

## *AUTHORIZATION AND ASSIGNMENT FOR ATTORNEY*

You are authorized to release any information you deem appropriate concerning my physical condition to my attorney in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I also authorize my attorney to direct payment to you of these charges interimly or at the time of settlement of my case, as per agreement between you and my attorney.

DATED: _____ PATIENT: ***/s/***_____
Printed name as signature

## *ACKNOWLEDGEMENT AND UNDERSTANDING FOR ATTORNEY*

I hereby acknowledge that I am ultimately responsible for payment of any charges incurred by me at the Family Chiropractic Center of Santa Fe. If my attorney is unable to accomplish a satisfactory settlement of my case and only has funds to partially reimburse all charges incurred, or if my attorney refuses to reimburse for all charges incurred, I will pay these charges immediately upon notification.

DATED: _____ PATIENT: ***/s/***_____
Printed name as signature

FAMILY CHIROPRACTIC CENTER OF SANTA FE 2019 GALISTEO ST. STE M6 SANTA FE, NM 87505

# PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

The Family Chiropractic Center of Santa Fe (FCC) is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from the FCC. This Notice details how your PHI may be used an disclosed to third parties, as well as your rights.

CONSENT: The FCC may use and/or disclose your PHI (provided that it first obtains a valid Consent signed by you) for the purposes of treatment (providing it to other physicians by request) and payment (to insurers for billing purposes).

NO CONSENT REQUIRED: The FCC may use and/or disclose your PHI without your consent based on the orders of another healthcare provider, in an emergency, as required by law, if there is a barrier to communicating with you, or by court order.

FAMILY/FRIENDS: The FCC may disclose your PHI to a family member or close personal friend identified by you.

YOUR RIGHTS: You have the right to revoke any consent, request PHI usage restrictions except in an emergency, inspect and copy your PHI, amend your PHI as provided by law, complain to the FCC if your privacy rights have been violated, and receive a copy of this Privacy Notice/Patient Consent.

FCC'S REQUIREMENTS: The FCC will maintain the privacy and confidentiality of your PHI as by law, reserves the right to change the terms of this notice for maximum PHI effectiveness, and will not retaliate against you for filing a complaint.

PATIENT CONSENT: The patient agrees that the above has been read and agreed to, that the FCC can change its privacy practices by law, that the FCC can use and/or disclose my PHI for purposes of treatment or obtaining payment, that I can request that the FCC restrict how my PHI is used and/or disclosed, that this consent is valid for 7 years, that the FCC can refuse to treat me if I refuse to sign below or revoke this consent.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

**/s/**_____ _____

Printed name as Signature Date

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

**/s/**_____ _____

Parent/Guardian/Represenative Printed name as Signature Date

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505-984-0006

# NOTICE REGARDING YOUR SIGNATURE

All paper documents that you fill out in this office that constitute part of your patient record will be scanned and entered into the office computer system.  The following statement below determines the legality of those signed documents.

***Photocopies, facsimiles, electronic, or other copies of documents which you have signed shall have the same effect for all purposes as an ink-signed original.***

By signing below, I certify that I have read and agree with the above statement.

_____

Patient, Parent, or Legal Guardian Signature

_____

Date