For office use only
Account Number:_____
Account Category:_____

900 E. Will Rogers Blvd, Ste. D – Claremore, OK 74017
Ph: 918.341.6535 – Fax: 918.341.6566 – www.claremorechiro.com

General Information

First Name _____Middle Initial_____Last Name_____
Suffix _____ Called Name_____
Address _____ City_____State_____
Zip Code _____Home Phone_____Work Phone_____
Cell Phone _____Other No._____
Birthdate _____Social Security_____
Email Address_____ Referred By _____
Emergency Contact_____ Phone_____

Sex Male Female
Race American Indian, Alaska Native, Asian
White, Black or African American, Native Hawaiian
Other, Pacific Islander, Declined to State
Ethnicity Declined to State, Hispanic or Latino
Not Hispanic or Latino
Language _____Marital Status Single Married Other_____
Spouse Name _____Spouse Phone_____
Work Status Employed Full-time student Part-time student
Family Medical Doctor _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female

Carrier Information

Name/code_____
Attn: _____
Address_____
City, State, Zip _____
Contact _____
Phone _____

Employer Information

Employer/Code_____
Attn:_____
Address_____
City, State, Zip_____
Contact_____
Phone_____

Condition Information

Related to Employment: Yes No
Related to Auto Accident: Yes No
Related to other Accident: Yes No

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

Frequency of Pain □Occasional □Intermittent □Frequent □None

Type of Pain □Aching □Burning □Dull □Pulling □Sharp □Shooting □Stabbing □Stinging □Throbbing □None

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

Frequency of Pain □Occasional □Intermittent □Frequent □None

Type of Pain □Aching □Burning □Dull □Pulling □Sharp □Shooting □Stabbing □Stinging Throbbing □None

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Frequency of Pain □Occasional □Intermittent □Frequent □None

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Frequency of Pain □Occasional □Intermittent □Frequent □None

Type of Pain □Aching □Burning □Dull □Pulling □Sharp □Shooting □Stabbing □Stinging □Throbbing □None

Do you have any current work restrictions due to this condition?

Off work: □Yes □No □Previously From:_____ To: _____

Light duty: □Yes □No □Previously (If yes, what are/were your restrictions?)

_____

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No

_____

List any past conditions you may have had:

_____

_____

_____

_____

Were you admitted to the hospital due to any of these conditions: □Yes □ No Condition_____

If yes, what hospital?_____Transported by? □Ambulance □Police □Other

Date Admitted:_____Date Released:_____Length of Stay: _____

Have you ever had any surgeries? □Yes □No (If yes, enter type and approximate date of surgery.)

_____

Have you ever had X-rays/MRI/CT'S taken? □Yes □No When? _____

For what ailments where these X-rays taken? _____

HABITS

□ Current everyday smoker □ Current some day Smoker

□ Former Smoker □ Never Smoker

□□Drinking Alcohol: (Cups/day):____ □ Coffee Cups/day:____

□ Soft Drink Bottles or Cans/day:___ □ Water Cups/day:____

EXERCISE

□ None

□ Moderate

□ Daily

FAMILY HISTORY

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

Are you taking any medications (prescription or over-the-counter)? □Yes □No

If Yes, please indicate the following

Medication:_____

Route: Oral
Intravenous
Other:_____

Frequency:_____

Began Use:_____

Discontinued Use:_____

Medication:_____

Route: Oral
Intravenous
Other:_____

Frequency:_____

Began Use:_____

Discontinued Use:_____

Medication:_____

Route: Oral
Intravenous
Other:_____

Frequency:_____

Began Use:_____

Discontinued Use:_____

Medication:_____

Route: Oral
Intravenous
Other:_____

Frequency:_____

Began Use:_____

Discontinued Use:_____

GENERAL SYPMTOMS

- ☐ Allergy (what)_____
- ☐ Bronchitis
- ☐ Headache
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Numbness in_____
- ☐ Wheezing

GASTRO-INTESTINAL

- ☐ Belching or Gas
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder
- ☐ Hemorrhoids (piles)
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heart Burn
- ☐ Bloody Stools

EYE/EARS/NOSE/THROAT

- ☐ Asthma
- ☐ Deafness
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear noises
- ☐ Thyroid Problems
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Pain in Eyes
- ☐ Poor vision
- ☐ Blurred Vision
- ☐ Sinusitis

RESPIRATORY

- ☐ Chest Pain
- ☐ Chronic cough
- ☐ Spitting blood
- ☐ Spitting Phlegm

GENITO-URINARY

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urination Control
- ☐ Kidney Infection
- ☐ Kidney stones
- ☐ Painful Urination

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- ☐ Appendicitis
- ☐ Arthritis
- ☐ Goiter
- ☐ Mumps
- ☐ Polio
- ☐ Lumbago
- ☐ Alcoholism
- ☐ Cancer
- ☐ Hepatitis
- ☐ Anemia
- ☐ Pneumonia
- ☐ Epilepsy
- ☐ Influenza
- ☐ Chicken Pox
- ☐ Tuberculosis
- ☐ Eczema
- ☐ Venereal Disease
- ☐ Heart Disease
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Mental Disorder
- ☐ Pleurisy
- ☐ Diabetes
- ☐ Whooping Cough
- ☐ HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and negatives will remain in the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature:_____ Date:_____

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed by this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSUANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect.

It is to be understood and agreed that any services rendered are charged to you directly and your personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. You must have authorization from your employer's Worker's Compensation insurance to be treated at this office. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your claim number, and tell us if you have retained an attorney. There are three options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection for Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for service are due immediately.

MEDICARE

We do accept assignment from Medicare. Payment is typically sent directly to our office for reimbursement of the services that Medicare will cover- which for Chiropractic is ONLY manual manipulation of the spine.

Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for many HMOs, including Community Care and Global Health.

These plans require a referral from the primary care doctor and/or the insurance company in order to be treated by the chiropractor. We can assist you in obtaining a referral. If you do not have the necessary referral, you will be responsible for all charges incurred.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a "flex plan". We will be happy to provide you with a statement of your charges for reimbursement.

GREEN FLAG/DEBT COLLECTION

Please be informed that if your account is overdue for 3 months without any payments made, you will be sent to our collection agency and $13.50 will be added to your bill for a collection fee.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Claremore Chiropractic & Rehab. I understand that my insurance is an agreement between myself and my insurance company, NOT between Claremore Chiropractic & Rehab and my insurance company. I request that Claremore Chiropractic & Rehab prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Claremore Chiropractic & Rehab, those fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) 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 will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. 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 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. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of patient Date

Claremore
CHIROPRACTIC
& REHAB

INFORMED CONSENT
DR. DRAKE GARDNER

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is and ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including but not limited to numbness, tingling and or bruising near the needling sites that may last a few hours or a few days. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax), dizziness, fainting, and possible infection. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of treatment procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____
Date

_____ _____
Printed name Signature

_____
Signature of Parent or Guardian (if minor)

PREGNANCY WAIVER

I hereby acknowledge that Dr. Drake Gardner of Claremore Chiropractic & Rehab Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated that on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed Name of Patient

_____ _____

Signature of Patient / Authorized Representative of patient Witness

_____

Date