# CLEGG CHIROPRACTIC

Today's Date_____

**ABOUT YOU:**

Patient name_____ Preferred Name_____
Last First M

Birthdate_____/_____/_____ Age_____ Social Security #_____ [ ] Male [ ] Female
MM / DD / YYYY

Mailing Address_____

City _____ State _____ Zip code_____

Mobile Phone #_____ Secondary Phone #_____

E-mail address_____

Status: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Spouse's name_____

Emergency contact_____ Relationship_____

Contact Number_____

**INSURANCE INFORMATION:**

Primary's name_____Relationship_____DOB_____
(MM/DD/YYYY)

Secondary Insurance_____

**REASON FOR VISIT:**

The reason for this visit is due to: [ ] Work [ ] Sports [ ] Auto [ ] Trauma [ ] Chronic [ ] Pregnancy

Explain what happened_____

Describe pain and location_____

When did the condition begin? _____/_____/_____

Is condition getting worse? [ ] Yes [ ] No [ ] Constant [ ] Comes and goes
Is this condition interfering with your [ ] Work [ ] Sleep [ ] Daily routine

If so, please explain_____

Have you had this or similar conditions in the past? [ ] Yes [ ] No

If so, please explain_____

Have you been treated by a Medical Physician for this condition? [ ] Yes [ ] No

If so, where? _____

Have you been treated by a chiropractor before? [ ] Yes [ ] No If so, whom?_____

**HEALTH HISTORY:**

List any medications you are currently taking:_____

_____

Do you have any of the following diseases or conditions?

| | | |
|---|---|---|
| Y N Heart attack | Y N Heart Surgery/pacemaker | Y N Heart murmur |
| Y N Congenital Heart defect | Y N Mitral valve prolapse | Y N Artificial valves |
| Y N Alcohol/drug abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV+/AIDS | Y N Shingles | Y N Cancer |
| Y N Frequent neck pain | Y N Emphysema/Glaucoma | Y N Anemia |
| Y N High/low blood pressure | Y N Psychiatric problems | Y N Stroke |
| Y N Severe/frequent headaches | Y N Kidney problems | Y N Ulcers/colitis |
| Y N Fainting/seizures/epilepsy | Y N Sinus problems | Y N Asthma |
| Y N Diabetes | Y N Difficulty breathing | Y N Chemotherapy |
| Y N Lower back problems | Y N Artificial bones/joints | Y N Arthritis |

List any other serious medical conditions_____

_____

Previous surgeries/treatments with dates_____

Past serious accidents with dates_____

Are you currently pregnant? [ ] Yes [ ] No Due Date_____

Allergies_____

Family health history_____

*We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with management. If account is not paid within 90 days of date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature Date

**Worker's Compensation Injury / Auto / Personal Injury:**

| | | | | |
|---|---|---|---|---|
| Have you filed an injury report with your employer? | [ ] | Yes | [ ] | No |
| Will you be filing through auto insurance? | [ ] | Yes | [ ] | No |
| Will you be filing through an attorney? | [ ] | Yes | [ ] | No |

**Assignment and Instruction for Payment to Clegg Chiropractic**

Private and Group Accident and Health Insurance

I hereby instruct and direct _____ Insurance Company to make direct payment to Clegg Chiropractic, P.C.

If my current policy prohibits payment to the doctor, then I hereby also instruct and direct you to make direct payment to Clegg Chiropractic, P.C. for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment according to the financial policy of the above assignee.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. This authorization and assignment to the office listed above shall be irrevocable for the full extent of my treatment by said doctor and until such time that my medical expenses incurred have been paid in full.

_____ Initials _____ Date

**Consent for Treatment of a Minor**

I, _____ being the parent, guardian, or custodian of

_____, a minor, do hereby authorize, request, and direct Clegg Chiropractic, P.C. to perform any necessary examination, and chiropractic treatment on the person of said minor.

_____ _____

Parent, guardian or custodian signature Date

**HIPAA Medical Release**

I, _____ (NAME)

[ ] **AUTHORIZE** OR [ ] **DO NOT AUTHORIZE**

Clegg Chiropractic to release my medical records to the following:

[ ] Other medical practitioners

[ ] Individual/s

Name: _____

Name: _____

**Re-disclosure:** I understand that Clegg Chiropractic cannot guarantee that the recipient/s listed above will not re-disclose my health information to a third party. The third party may not be required to abide by this contract or applicable to federal and state law governing the use and disclosure of my health information.

_____

PRINTED NAME SIGNATURE DATE

If patient is unable to sign or is a minor, please complete the information below

_____

NAME OF GUARDIAN/REPRESENTATIVE SIGNATURE DATE

**Cancellation & No Show Policy**

Our office has a 24-hour cancellation policy. We reserve the right to charge a **$25 fee** for appointments cancelled with less than 24 hours' notice. If it is necessary to cancel or reschedule your appointment we require that you call or leave a message. We also reserve the right to charge a $25 fee for appointments missed without calling.

Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely care.

You are required to pay the cancellation fee prior to the start of your next visit. Cancellation fees cannot be billed to insurance.

_____ Initials _____ Date

# CLEGG CHIROPRACTIC
# NOTICE OF PRIVACY PRACTICES

This notice describes how judicial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice or our privacy practices. You have the right to the confidentiality of your medical information and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect; and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the privacy officer at this practice.

**Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical records, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries and business associates may share medical information with each other for treatment, payment purposed of healthcare operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

**How We May Use and Disclose Medical Information About You**

The following categories describe different ways we may use and disclose medical/chiropractic information without your specific consent or authorization. Examples are provided for each category of used or disclosures. Not every possible use of disclosure in a category is listed.

**For Treatment:** We may use medical information about you to provide you with chiropractic treatment or service. Example: In treating you for a specific condition, we may need to know if you have had surgery on the area being treated.

**For Payment:** We may use and disc lose medical/chiropractic information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company, or a third party. Example: we may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations:** We may use and disclose medical/chiropractic information about you for health c are operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses or Disclosures That Can Be Made Without Consent of Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by Military Command authorities for their medical records
- To workers' compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner to identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the U.S. Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

**Uses and Disclosures of Protective Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use of disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care we have provided you.

## Notice of Privacy Practices - Patient Acknowledgment

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident or controlled by this practice. If changes to this policy occur, this practice will provide a revised Notice of Privacy Practices upon request.

| _____ | _____ | _____ |
|---|---|---|
| PRINT PATIENT NAME | SIGNATURE | DATE |

## Clegg Chiropractic COVID-19 Waiver

Clegg Chiropractic would like to inform you of the steps we are taking in our clinic regarding COVID-19 to keep our staff and patients safe.

- We continue to clean and disinfect the tables and equipment in each room after each patient.
- We frequently disinfect the high touch surface areas: chairs, door handles, pens etc.
- We space out our appointments in a way that avoids prolonged patient interaction and enables the ability to practice safe social distancing.
- We disinfect the office each night with a professional Ozone generator/UV air cleaner.
- We require all individuals to wear a mask while in the office.

The following are recommendations that can help avoid contracting or spreading of COVID-19:

- Wash your hands frequently for at least 20 seconds
- Use hand sanitizer with a 60% alcohol content or higher
- Avoid touching your face

If you are feeling unwell, even if symptoms are mild, if you have traveled in the last 14 days or have been exposed to COVID-19 please do not come in. Call the office to cancel and/or reschedule. We are doing our utmost to provide safe care to our patients.

In safety and in health,
Dr. Charles Clegg, Dr. Bradley Clegg, & Dr. Kathleen Burke

Please sign below stating that you understand that Clegg Chiropractic is following the recommendations of the CDC and doing our utmost to provide safe care to our patients and that you are willingly continuing to seek care from our facility at this time.

| _____ | _____ | _____ |
|---|---|---|
| PRINT PATIENT NAME | SIGNATURE | DATE |