

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## △ PATIENT INFORMATION

Name: (Last, First MI) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender: M / F Marital Status: Married / Other / Single  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student Status: Full Student / Part Student / Non-Student  Employed Employer: \_\_\_\_\_  
\*Referred By: \_\_\_\_\_

Ethnicity: Hispanic or Latino / Other

Preferred Language: \_\_\_\_\_

Race: Asian / African Am. / Am. Indian or Alaskan Native /  
Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

## △ EMERGENCY CONTACT INFORMATION

Full Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_  
Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

## △ FINANCIAL INFORMATION

Insurance  Worker's Comp  Self-Pay (Cash)  Personal Injury/Auto  Other (please explain): \_\_\_\_\_

### PRIMARY INSURANCE

Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other  
*Other than Self:*  
Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### SECONDARY INSURANCE

Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other  
*Other than Self:*  
Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who is responsible for payment? Self / Other - (Relationship) \_\_\_\_\_

*Other than Self:*

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Patient No: \_\_\_\_\_

# PATIENT CASE HISTORY

## **Ⓢ** HISTORY OF CURRENT CONDITION

Describe Major Complaint: \_\_\_\_\_

Began When? \_\_\_/\_\_\_/\_\_\_ Describe how this began: \_\_\_\_\_

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: \_\_\_\_\_

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) \_\_\_\_\_

Head - Base of Skull / Forehead / Sides-Temple R / L / Both Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both Other Area: \_\_\_\_\_

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: \_\_\_\_\_

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: \_\_\_\_\_

Which daily activities are being affected by this condition? (Describe) \_\_\_\_\_

**For this CURRENT condition, have you:**

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: \_\_\_\_\_ Where? \_\_\_\_\_

• Had any previous Surgery or Interventions in this area? (Describe) \_\_\_\_\_

• Taken any Medications? OTC / Prescriptions \_\_\_\_\_

• Had any diagnostic testing? X-rays / MRI / CT / Other: \_\_\_\_\_ When and Where? \_\_\_\_\_

Describe any Secondary Complaints: \_\_\_\_\_

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITION II SPACE IS NEEDED)

### **Ⓢ** Medications:

Allergies to Medications: NONE (List) \_\_\_\_\_

Current Medications: NONE  
(Already have a list? We can make a copy.) \_\_\_\_\_

### **Ⓢ** Past Health History: (Please list any past...)

Surgeries - Date, Type, and Reason: NONE \_\_\_\_\_

Major Injuries/Traumas: NONE \_\_\_\_\_

Major Hospitalizations: NONE \_\_\_\_\_

Patient No: \_\_\_\_\_

### **Ⓢ** Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

### **Ⓢ** Social and Occupational History:

Level of Education Completed: \_\_\_\_\_

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

### Habits:

Cigarettes - (#/day) \_\_\_\_\_

Alcohol - (amount/day) \_\_\_\_\_

Coffee/Tea - (cups/day) \_\_\_\_\_

Rec. Drugs (List) \_\_\_\_\_

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

Infertility

- Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

**AUTHORIZATION**

The following uses and/or disclosures specifically require your express written permission:

**Marketing Purposes** - We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

**Sale of Health Information** - We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

**YOUR RIGHTS**

**Right to Revoke Authorization** - You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

**Right to Request Restrictions** - You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

**Right to Receive Confidential Communications** - You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work. If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

**Right to Inspect and Copy** - You have the right to inspect and request copies of your information. I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Benningfield Chiropractic Clinic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

**Right to Amend** - If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

**Right to an Accounting of Disclosures** - You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

**Right to a Paper Copy of this Notice** - You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

**Right to File a Complaint** - You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows: Robert Benningfield, DC - 2783 Charlotte Hwy 21 Suite 23, Mooresville, NC 28117 - We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation. I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

X Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Informed Consent to Treatment**

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by Robert Benningfield, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Benningfield Chiropractic Clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Box containing signature lines for Patient Name Printed, Date, Patient Signature, and Parent/Guardian's Signature.

DO NOT WRITE BELOW THIS LINE

Patient Accepted?

YES

NO

Doctor's Signature

Handwritten signature of Robert Benningfield, D.C.

A. Notifier: Dr. Robert Benningfield DC

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. SERVICES below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. SERVICES below.

D. Service(s)	E. Reason Medicare May Not Pay:	F. Estimated Cost
1.) Adjustments of the spine	1.) Wellness/Maintenance care is not covered by Medicare and is not considered medically necessary.	1.) \$27.39
2.) Exam	2.) Not covered by Medicare	2.) \$100
3.) X-Rays	3.) Not covered by Medicare	3.) \$100

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. Services listed above.  
**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: ~~Check only one box. We cannot choose a box for you.~~

- OPTION 1.** I want the D. Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. Services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

### H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

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