Campion Chiropractic Clinic

Patient Registration – WELCOME!

Today's Date: ____________________ Lead Dr: S C

Full Name: ____________________ Sex: ☐ Male ☐ Female

Marital Status: ☐ S ☐ M ☐ D ☐W Spouse's Name: ____________________ # of Children: ________

Address: ____________________ City/State: ____________________ Zip Code: ________

Birthday: ____________ Age: ______ Social Security #: ____________________

Employer: ____________________ Profession: ____________________

Cell #: ____________ Home #: ____________ Work #: ____________

Email: ____________________ ☐ Si no quieres boletines, tic aquí.

How would you like to be contacted? ☐ Home # ☐ Cell # ☐ Text ☐ Email

How did you hear about us? ____________________ Which Dr.? ____________

Emergency Contact: ____________________ Phone #: ____________ Relation: ____________

Medical Doctor: ____________________ Address: ____________________ Phone #: ____________

Main Concerns: (1)____________________ (2)____________________ (3)____________________

Is this the result of an accident? ☐ Car ☐ Work ☐ Other

Accident Date? ____________ Do you have an attorney? ☐ Yes ☐ No

Claim #: ____________ Adjuster's Name: ____________ Phone #: ____________ Fax #: ____________

Address: ____________________ City/State: ____________________ Zip Code: ________

Insurance Carrier: ____________________ Phone #: ____________

Policy #: ____________________ Group #: ____________________

Policyholder's Name: ____________________ SS#: ____________ Birthday: ____________

I, ____________________, agree that I am ultimately responsable for payment of any balances on this account. I will help handle any negotiations with my carrier, or any other involved parties, that may be needed to settle my account. I also agree to pay for any treatment considered in excess and/or in exclusion of my carrier coverage.

Patient Signature: ____________________ Date: ____________

Guardian's Signature: ____________________ Date: ____________

Witness: ____________________ Date: ____________

Application for Treatment

1. **Where do you have pains or concerns?** (*Please check all that apply*)
   - ☐ Headache ☐ Jaw ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back
   - ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand
   - ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot
   - ☐ Other: ______________________________

2. **Which of those areas is your main concern today?** ______________________________

3. **What do you think caused this problem?** ______________________________

4. **How severe is your concern <u>at its worst</u>?** (Number 0 = no symptoms. Number 10 = worst symptoms ever.)
   ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

5. **What does it feel like?** (*Please check all the apply*)
   - ☐ Burning ☐ Catching ☐ Dull Ache ☐ Numb ☐ Pinching ☐ Pins/Needles
   - ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling
   - ☐ Other: ______________________________

6. **How often do you feel it?**
   ☐ 75% - 100% of the day ☐ 51% - 75% of the day ☐ 26% - 50% of the day ☐ 1%-25% of the day

7. **What are your goals for coming here?** (*Please check all that apply*)
   - ☐ Become Pain Free ☐ An Explanation of my Condition ☐ Learn how to care for this on my own
   - ☐ Reduce Symptoms ☐ Resume Normal Activity ☐ Other: ______________

8. **Do any of the following make you feel worse? Are any difficult to do?** (*Please check all that apply*)
   - ☐ Getting in/out of bed ☐ Turning/moving in bed ☐ Using the restroom ☐ Bathing/showering
   - ☐ Getting dressed ☐ Cooking/preparing food ☐ Chewing/swallowing ☐ Getting up from a chair
   - ☐ General movement ☐ Cleaning after a meal ☐ Performing housework ☐ Caring for children/parents
   - ☐ Caring for pets/animals ☐ Yardwork ☐ Using a computer ☐ Using your phone
   - ☐ Shopping ☐ Attending social events ☐ Exercising ☐ Participating in sports
   - ☐ Getting in/out of your car/truck ☐ Riding/driving in your car/truck
   - ☐ Others: ______________________________

9. **What makes you feel better?**
   - ☐ Acupuncture ☐ Active Release Technique (ART) ☐ Chiropractic ☐ Cold Laser
   - ☐ Graston ☐ Heat ☐ Ice ☐ Lying Down
   - ☐ Massage ☐ Decompression/Inversion ☐ NOTHING ☐ Pain Medicines
   - ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Other Therapy
   - ☐ Other: ______________________________

10. **Have you seen anyone else for this concern?** ______________ **When?** ______________
    What did they recommend or what treatments did they do? ______________________________

11. **Do you have any of the following medical conditions?**
    - ☐ AIDS/HIV ☐ Cancer ☐ Glaucoma ☐ Kidney Disease ☐ Polio ☐ STD
    - ☐ Alcoholism ☐ Depression ☐ Heart Disease ☐ Lung Disease ☐ Prostate Prob. ☐ Stroke
    - ☐ Anemia ☐ Diabetes ☐ Hepatitis ☐ Lupus ☐ Scoliosis ☐ Thyroid Disease
    - ☐ Arthritis ☐ Diverticulitis ☐ High BP ☐ Muscle Disease ☐ Seizures ☐ Tuberculosis
    - ☐ Asthma ☐ GERD ☐ Joint Replaced ☐ Migraines ☐ Sinus Troubles ☐ Ulcers
    - ☐ Others: ______________________________

12. **What are your lifestyle habits?**
    - ☐ Tobacco _____ (# cigs/day) ☐ Alcohol _____ (# drinks/day) ☐ Recreational Drugs
    - ☐ Caffeine _____ (#drinks/day) ☐ Sleep _____ (# hours/night) ☐ Exercise _____ (# hours/week)

WOMEN: Are you pregnant? ☐ Yes ☐ No ☐ Uncertain

WARNING: *If you are or might be pregnant and do not notify the doctor, this could be hazardous to you or your baby's health and this office will not be held responsible.*

X-Ray Consent - Patient Signature: ______________________

Campion Chiropractic Clinic

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by a licensed Doctor of Chiropractic working at this clinic or office or serving as a backup for the Doctors at this clinic.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain
- No improvement of symptoms or pain
- Infection (acupuncture)
- Punctured lung (acupuncture)
- Other ______________________________

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. The reported complication of artery dissection by chiropractic cervical adjustment is rare and has been reported in approximately 1 out of a million treatments. To put that risk into perspective, complications from aspirin are 1 in ten thousand, and birth control 1 in five thousand.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. The doctor cannot be responsible for any pre-existing medically diagnosed conditions.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan, and I intend this consent to cover the entire course of treatment for my current condition(s).

Unsworn Declaration of Notary

My name is ______________________________ [first–middle-last], my date of birth is ____________.

My address is ____________________________, ________________________, Texas, ________ [zip], USA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Brazos County, State of Texas, on the ____ day of ________________, 20___

Patient or Responsible Party: ______________________________

Printed Name: ______________________________

To be completed by doctor or staff:

______________________________ ________________

witness to patient's signature date

______________________________ ________________

translated by date

CCC 113 – 2019.02.20

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your Protected Health Information (herein "PHI") will be used or disclosed to others for the purposes of your treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Some of these include having your name on a sign-in sheet, posted on a referral board, and used on charts and records that may be seen by others while in this office. We may also use various means of contacting you including phone calls, emails, and mail-outs such as appointment cards, birthday cards, and newsletters. Our office may leave messages on your phone, voice recorder, send emails or text messages to you that may contain PHI. This office utilizes an open treatment and therapy areas where your PHI may be heard or seen by other patients. We also consider this protected PHI.

You must list any restrictions on the release of your PHI below. Campion Chiropractic reserves the right to accept or deny those listed below based on our PHI Notice information.

☐ No restrictions

☐ Restrictions: ____

You should review the Notice of Privacy Practices (herein "Notice") that was received by you (if requested) and posted on the wall in the reception area for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of any health information, including your demographic information, collected from you and created or received by this office.

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

You have the right to revoke this consent which must be done **in writing**. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. ***This office reserves the right to modify the privacy practices outlined in the Notice.***

I have reviewed this Consent Form and the Notice (as posted or requested), and give my permission to be examined, treated, and receive any examinations and office procedures that the provider deems necessary. I also allow this office to use and disclose my PHI in accordance with that stipulated above and in the Notice.

Patient's Signature ______________________________ Date Signed ______________

Patient/Guardian's Name (printed) ______________________

If Guardian, please list relationship ______________________

Witness Signature ______________________________ Date Signed ______________

Reviewed with Patient: Dr. Init ______

Karen M. Campion, D.C., P.A.

FINANCIAL POLICY

PATIENT NAME: ____________________________

Karen M. Campion, D.C., P.A., dba Campion Chiropractic and Sports Injury Clinic, and her staff welcome you to our office and are here to serve your healthcare needs and appreciate the opportunity to do so. We have sincerely endeavored to keep your health care costs in this office as reasonable as possible so that you may feel financially, as well as physically comfortable while pursuing the ultimate heath that chiropractic provides. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is out hope that you will take responsibility for your financial obligation to our practice/office. The following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. INSURANCE – As a courtesy to our patients, we will verify your insurance at or before your first visit to our office. We will file claims on all visits and procedures performed in our office. Fees are based on the contracted insurance company's guidelines. Depending on your insurance carrier, these fees may vary. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Karen M Campion, D.C., PA (that is, the insurance company will pay Karen M Campion, D.C., PA directly). You are responsible for payment of all deductibles, co-insurance, co pays, and non-covered services. Please remember, insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and payment to your doctor rests with you.

2. REFERRALS - We gladly accept referrals from other doctor's offices. You are requires to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see the doctor. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits, so you should be careful to monitor the dates and visits. If your insurance company requires a valid referral for evaluation/treatment and you do not have one, you will be rescheduled for another day.

3. NO INSURANCE – Patients who do not have insurance are expected to pay for all services rendered on the day of treatment. We understand that individual situations may make it difficult to meet these financial expectations and we are happy to discuss payment arrangements as needed based on treatment recommendations.

4. RETURNED CHECKS – Your account will be charged a $30 fee for each returned check. In addition, you will be asked to bring cash/money order to our office to cover the returned check amount and fees incurred.

5. PAST DUE ACCOUNTS – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligations to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, plus pay for any fees incurred from the agency. You will be expected to pay for any future services in advance, before being seen by our doctors.

6. NON-COVERED SERVICES – Medicare and certain insurance companies will only pay for services which they determine to be "reasonable and necessary". If Medicare or another insurance company determines that your visit with our doctors/clinic is not "reasonable and necessary", then they will deny payment for that service. Sometimes insurance companies will not cover an office visit/examination prior to procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need visit with the doctor/clinic beforehand.

Our doctors/clinic recommends a consultation and/or spinal screening prior to any treatment or procedures in order to evaluate the patient's history and general health. The patient will then be informed about any examinations, physical therapy, acupuncture, spinal decompression, Graston, therapeutic exercises, and other diagnostic tests that may be needed in order to diagnose your condition and start treatment. We are required to inform you that your insurance company may not cover the consultation/office visit/examination/spinal manipulation/spinal decompression/acupuncture and/or physical therapy modalities and that you will be responsible for payment.

If for any reason, after a thorough consultation, examination and x-rays (if necessary), your problem is NOT a chiropractic case, or that we CANNOT help you, we will advise you of such and refer you to someone we think can help you.

Patient Statement:

I have been informed of Karen M Campion, D.C., P.A.'s financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit/examination or other procedures and treatments for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment.

Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________

Campion Chiropractic Clinic

PATIENT REQUEST FOR RECORDS

Name: ______________________ Patient DOB: __________ Date: ___________

I hereby authorize the release of the following records, or copies of the following records, to be transferred from ____________________________________, and sent to:

Campion Chiropractic Clinic
3120 Texas Avenue South
College Station, TX 77845

Check all that apply below:

___ Medical Records
___ X-Ray Report / Films
___ CT Report / Films.
___ MRI Report/Films
___ Labs
___ Other: ______________________

I understand that this authorization is valid for no more than 1 year and may be cancelled anytime upon verbal or written request made directly to Campion Chiropractic Clinic.

Please FAX this form or drop off in person to protect your HIPAA information.

Patient / Guardian's Signature: ______________________ Date: ___________

Witness: ______________________ Date: ___________