2017 E H R UPDATE

Patient Name: _____ DOB: _____

Please initial if you would like to electronically have access to your health information: _____

Please initial if you would like appointment reminders via email and/or text message: _____

2017 Insurance: _____ Policy Number: _____

Guarantor: _____ DOB: _____

Medications: _____

_____

_____

_____

Allergies: _____

_____

_____

Has any doctor diagnosed you with **Hypertension** presently? Yes No If Yes, describe:

_____

_____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

Have you had an **X-Ray** or **CT** scan or **MRI** within the past 6 months? Yes No If yes, where?

Family Physician: _____

Surgeries: _____

Preferred Pharmacy: _____

Phone Number to reach you: _____

Patient Signature: _____
Date: _____
Parent/Guardian: _____
Date: _____

FOR OFFICE USE:
Height: _____ Weight: _____ BP: _____

APPLICATION FOR CARE AT HENNINGTON WELLNESS CENTER

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ **Referred By:** _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____ Relationship: _____

Please initial if you would like to electronically have access to your health information: _____

Please initial if you would like appointment reminders via email and/or text message: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number***:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

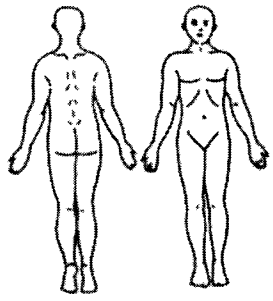
How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

FOR OFFICE USE:

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past,*** **C** for ***Currently*** have and **N** for *Never have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

Medications:_____

_____

Allergies:_____

_____

Has any doctor diagnosed you with **Diabetes** presently: Yes No If yes, what kind? Type 1 Type II
Has any doctor diagnosed you with **Hypertension** presently: Yes No If Yes, please describe:

_____

SOCIAL HISTORY

1. **Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage**: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
   If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
   Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. **Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

PREFERRED METHOD OF CONTACT: □ Phone Call □ Text Message □ Email

I hereby authorize payment to be made directly to Hennington Wellness Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Hennington Wellness Center for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

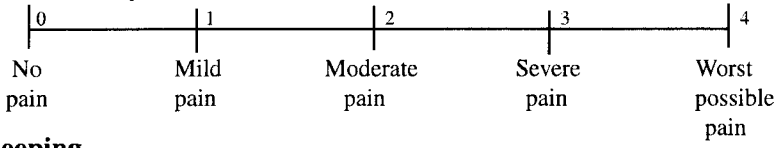
Patient's Name: _____ **HR#:** _____ ___/___/___ HWC, 3/15

Functional Rating Index

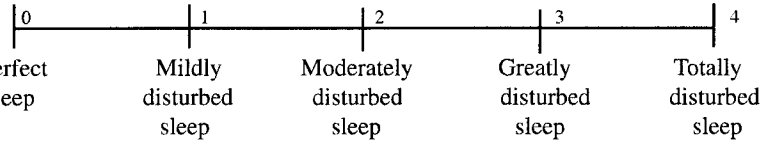
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

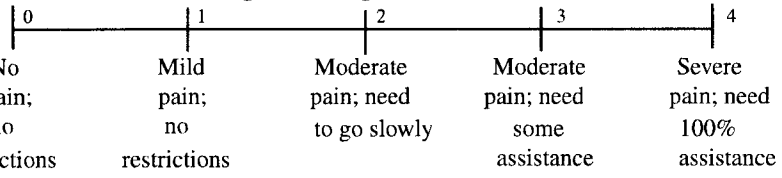
1. Pain Intensity



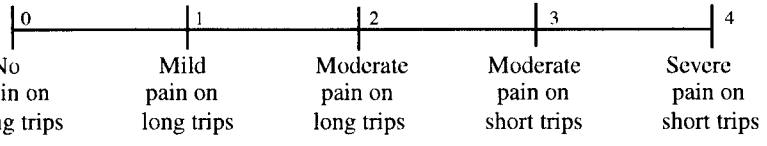
2. Sleeping



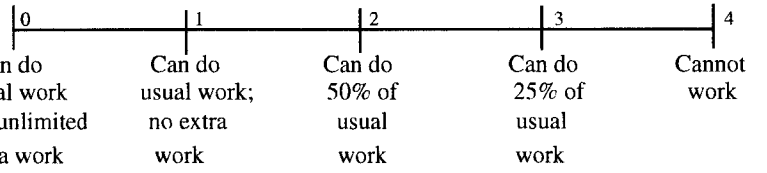
3. Personal Care (washing, dressing, etc.)



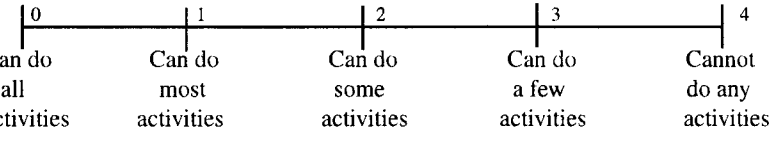
4. Travel (driving, etc.)



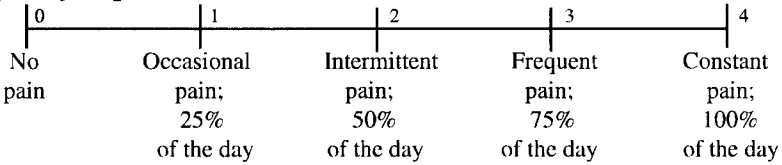
5. Work



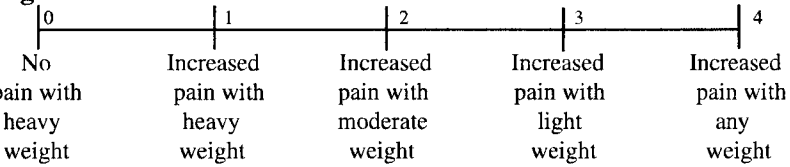
6. Recreation



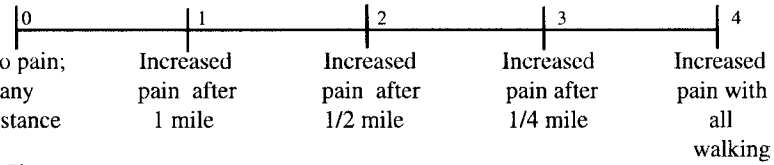
7. Frequency of pain



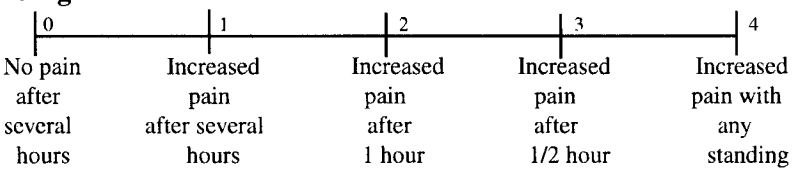
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

HENNINGTON
WELLNESS CENTER

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I(we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice at Hennington Wellness Center. I have had the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected by rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to, fractures, disc injuries, strokes and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive. I have read, or the above information has been explained regarding consent I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment. _____

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period: _____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plays make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted. _____

INFORMED CONSENT TO PARTICIPATE IN ACTIVE TREATMENT

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney and DVR manager, if it is applicable. If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best change of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program. Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed to early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED. _____

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW:

_____ I AGREE TO PARTICIPATE

_____ I DO NOT WISH TO PARTICIPATE

HENNINGTON
WELLNESS CENTER

PATIENT CONSENT FOR RELEASE OF INFORMATION

By signing this form, you are granting consent to Hennington Wellness Center to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 601-680-0371. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title SVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

SIGNATURE ON FILE

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

_____
Print Patient's Name

_____
Patient's Signature

_____
Other Than Patient, Print Name and Relationship

There are "open areas' in the office such as hallways, reception areas, etc. where exchange of information may be overheard by others. As an office, we do our best to avoid initiating conversations relative to clinical information where others can overhear it and private areas are always available upon request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Hennington Wellness Center's Notice of Privacy Practices for protected health information.

_____
Date

_____
Patient's Signature/Personal Representative

HENNINGTON
WELLNESS CENTER

EST. 1906

RECORD RELEASE AUTHORIZATION

Doctor/Hospital: _____

Address: _____

_____

_____

I hereby authorize and request the release of my medical records to:

Hennington Wellness Center
220 Scott Drive
McComb, MS 39648
601.680.0371

Thank you in advance for your cooperation.

_____

_____
Patient's Signature Date

_____
Patient's Name (Please Print) Date of Birth

_____
If Patient is a Minor, Signature of Parent or Legal Guardian Relationship to Patient

_____
Witness To The Above Signatures