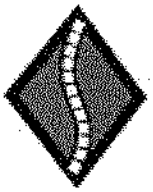


Short Chiropractic

BACK TO HEALTH

Brett A. Short, D.C.
Eric Cooper, D.C.
Destiny Cooper, D.C.

Patient Information _____ **Date:** _____

Name _____ Marital Status: ☐Married ☐Single ☐Divorce ☐Widowed

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

Home Phone #: _____ Cell Phone: _____ Work Phone: _____

Age: ____ Date of Birth: _____ SS#: _____ Sex: M F Height: _____ Weight: _____

Email: _____ Student: Full-Time ___ Part-Time___ Name of School: _____

Your Occupation: _____ Employed by: _____

Your Spouse Name: _____ Spouse Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

Name of person to contact in case of emergency: _____ Phone: _____

Name of nearest relative not living with you: _____ Phone: _____

Who referred you to this office so we may thank them? _____

Referring Physician: _____

Is your visit due to an accident? Yes/ No ☐Auto ☐Work Date of Injury: _____

Have you had Chiropractic in the past? Yes / No If yes, When? _____

Doctor's Name: _____ Results: _____

Who is your Medical Doctor? _____ Last Visit: _____

TREATMENT OF MINOR (must be signed by parent or legal guardian if patient is a minor under age 18). I hereby authorize Short Chiropractic Inc. and its assistants to administer chiropractic are as deemed necessary to my _____. (relationship)

_____ _____

Signature of Parent/Guardian **Date**

Insurance Coverage Information

Primary Insurance Carrier: _____ Phone: _____

Policy Holder Name: _____ Policy Number _____

Group Number _____ Relationship: ☐Self ☐Spouse ☐Child ☐Other

Insured Date of Birth: _____ Insured Home Phone: _____ Insured Work: _____

Secondary Insurance Carrier: _____ Phone : _____

Policy Holder Name: _____ Policy Number _____

Group Number _____ Relationship: ☐Self ☐Spouse ☐Child ☐Other

Insured Date of Birth: _____ Insured Home Phone: _____ Insured Work: _____

Auto / Personal Injury: Do you have "Med Pay" on your Auto Policy: Yes / No Amount: $ _____

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim Number: _____

DESCRIBE MAJOR COMPLAINTS & SYMPTOMS: _____

_____

_____

Where is your pain? How does it feel? Draw your pain using the following key.

KEY:

Stabbing / / /

Burning X X X

Pins O O O

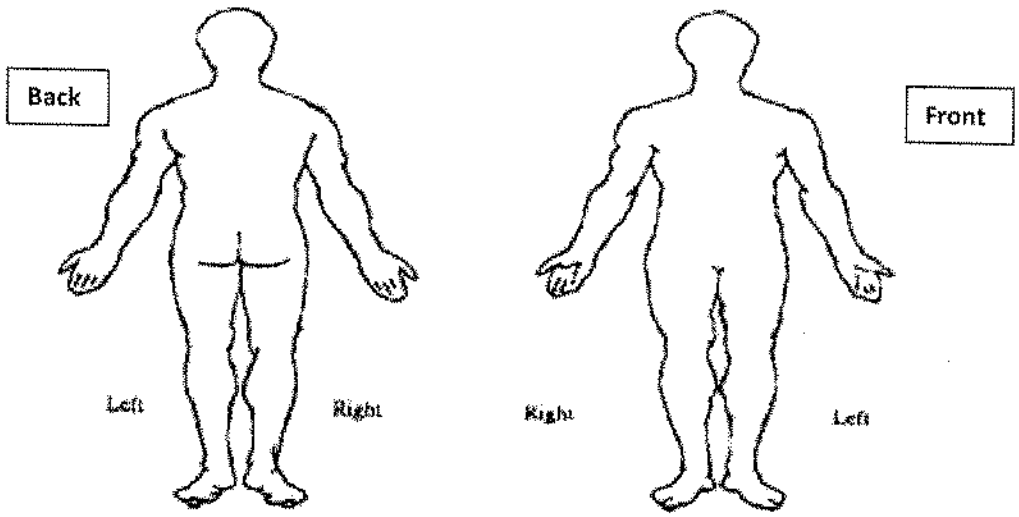
And Needles

Aching, ^ ^ ^

Throbbing

Numbness = = =

Other • • •



List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____

2. _____ Specialty _____

3. _____ Specialty _____

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____

2. _____ Date: _____ Dr: _____

3. _____ Date: _____ Dr: _____

Are you allergic to any medication? ____ Please list: _____

_____

Are you taking any medications? _____Please list: _____

_____

Do you wear Orthotics (shoe inserts)? Yes / No If yes, what type? _____

Please check the appropriate box for any of the following symptoms which you currently have.

	Occasional	Frequent
GENERAL		
Allergies	☐	☐
Convulsions	☐	☐
Dizziness or Fainting	☐	☐
Headache	☐	☐
Neuralgia	☐	☐
Numbness/sensation loss	☐	☐
MUSCLE & JOINT		
Arthritis	☐	☐
Bursitis	☐	☐
Foot Trouble	☐	☐
Low back pain	☐	☐
Neck pain or stiffness	☐	☐
Pain between shoulders	☐	☐
Sciatica	☐	☐
Swollen Joints	☐	☐
Pain, numbness/ cramps	☐	☐
Shoulders	☐	☐
Arms	☐	☐
Elbows	☐	☐
Hands	☐	☐
Hips	☐	☐
Legs	☐	☐
Knees	☐	☐
Feet	☐	☐

	Occasional	Frequent
GASTRO-INTESTINAL		
Colon Trouble	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficult digestion	☐	☐
Distension of abdomen	☐	☐
Gallbladder Trouble	☐	☐
Hemorrhoids	☐	☐
Liver trouble	☐	☐
Pain of stomach	☐	☐
Difficult swallowing	☐	☐
EYES,EARS,NOSE,&THROAT		
Asthma	☐	☐
Colds	☐	☐
Hearing loss	☐	☐
Earache	☐	☐
Ear Discharge	☐	☐
Ear noises	☐	☐
Eye pain	☐	☐
Nasal obstruction	☐	☐
Nosebleeds	☐	☐
Sinus infection	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐

	Occasional	Frequent
CARDIO-VASCULAR		
Hardening of arteries	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Pain over heart	☐	☐
Poor circulation	☐	☐
Rapid heartbeat	☐	☐
Slow heartbeat	☐	☐
Swelling of ankles	☐	☐
Slurred speech	☐	☐
Weakness/Clumsiness	☐	☐
RESPIRATORY		
Chest pain	☐	☐
Chronic Cough	☐	☐
Difficult breathing	☐	☐
Spitting up blood	☐	☐
Spitting up phlegm	☐	☐
Wheezing	☐	☐
GENITO-URINARY		
Bed-wetting	☐	☐
Blood in urine	☐	☐
Frequent urination	☐	☐
Inability to control kidneys	☐	☐
Kidney infection or stones	☐	☐
Painful irritation	☐	☐
Prostate trouble	☐	☐
Pus in urine	☐	☐

	Occasional	Frequent
SKIN		
Bruise	☐	☐
Dryness	☐	☐
Skin eruptions (rash)	☐	☐
Varicose veins	☐	☐
FOR WOMEN ONLY		
Congested breasts	☐	☐
Cramps or backache	☐	☐
Hot flashes	☐	☐
Irregular cycle	☐	☐
Lumps in breast	☐	☐
Menopausal symptoms	☐	☐
Painful menstruation	☐	☐
Vaginal Discharge	☐	☐

Pregnant ☐yes ☐no

Date of Last Period _____

Previous Miscarriages? ☐yes ☐no

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐

	None	Light	Moderate	Heavy
Drugs	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Relevant medical history: (Please circle the conditions you have or had previously)

Aids/HIV
Alcoholism
Arthritis
Asthma
Anemia
Appendicitis
Arteriosclerosis
Back pain or spasm
Cancer
Chicken Pox
Concussion
Convulsion
Diabetes
Digestion problems
Dizziness
Eczema
Emphysema
Epilepsy
Fibromyalgia
Foot Problems
Goiter
Gout
Hand or wrist pain
Headaches
Heart problems
Hepatitis
High blood pressure
Measles
Multiple Sclerosis
Mumps
Muscular Dystrophy
Neck pain or spasms
Numbness
Pacemaker
Pneumonia
Polio
Rheumatic Fever
Scarlet Fever
Sciatica
Scoliosis
Sinus trouble
Stroke
Tuberculosis
Typhoid Fever
Ulcers
Venereal disease

Does anyone in your family have a similar health related problem? Yes / No

Who: _____ What condition: _____

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I hereby authorize and direct my medical benefits to be paid to Short Chiropractic Inc and agree that I am financially responsible for non-covered services or items. I hereby give permission to Short Chiropractic Inc. to administer treatment and perform such general procedures as the doctor may deem necessary in the diagnosis and/or treatment for my condition.

Patient's Signature: _____ Date _____

Parent or Guardian: _____

Signature: _____ Date _____

Short Chiropractic
BACK TO HEALTH

Brett A. Short. D.C.

99 Cracker Barrel Dr. Suite 200, Barboursville, WV 25504
Phone: (304) 733-4616 | Fax: (304) 733-4818
Website: www.ShortChiro.com

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, payment from insurance company(proof of medical necessity), and law enforcement activities. Any other disclosures for purpose of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Patient Signature: _____
The effective date of this notice of information practice is _____.

Thank you

SHORT CHIROPRACTIC INC
BRETT A. SHORT,D.C.
99 CRACKER BARREL DRIVE, SUITE 200
BARBOURSVILLE, WV 25504
(304)733-4616 FAX: (304)733-4818

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. **SHORT CHIROPRACTIC INC.'S** Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information, PROTECTED HEALTH INFORMATION necessary for **SHORT CHIROPRACTIC INC.** to provide treatment to me, and also necessary for **SHORT CHIROPRACTIC INC.** to obtain payment for that treatment and to carry out this health care operations. **SHORT CHIROPRACTIC INC.** explained to me that the Privacy Notice will be available to me in the future at my request. **SHORT CHIROPRACTIC INC.** has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. **SHORT CHIROPRACTIC INC.** reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders, newsletters, and birthday cards, that will be used by **SHORT CHIROPRACTIC INC.**:
a) a postcard mailed to me at the address provided by me: and
b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
c) birthday cards
d) newsletter

4. **SHORT CHIROPRACTIC INC.** may use and/or disclose my PROTECTED HEALTH INFORMATION (which includes information about my health or condition and the treatment provided to me) in order for **SHORT CHIROPRACTIC INC.** to treat me and obtain payment for that treatment, and as necessary for **SHORT CHIROPRACTIC INC.** to conduct its specific health care operations.

5. I understand that I have a right to request that **SHORT CHIROPRACTIC INC.** restrict how my PROTECTED HEALTH INFORMATION is used and/or disclosed to carry out treatment, payment and/or health care operations. However, **SHORT CHIROPRACTIC INC.** is not required to agree to any restrictions that I have requested. If **SHORT CHIROPRACTIC INC.** agrees to a requested restriction, then the restriction is binding on **SHORT CHIROPRACTIC INC.**

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that **SHORT CHIROPRACTIC INC.** has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, **SHORT CHIROPRACTIC INC.** has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then **SHORT CHIROPRACTIC INC.** will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):
Date Signed ____/____/____ Witness. Lisa Boling

Short Chiropractic Inc

99 Cracker Barrel Drive, Ste. #200; Barboursville, WV 25504

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 unless prior arrangements have been made with the billing department. Our payment plans 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 unless prior arrangements are made with the billing department. 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 verify and accept your insurance coverage.

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.

I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

When your schedule of visits is once per month or longer, you may not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan.

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.

Patient's Printed Name: _____

Signature: _____ Date: _____

WITNESS: Lisa Boling Date: _____

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as appears on card: _____

SHORT CHIROPRACTIC INC
99 CRACKER BARREL DRIVE SUITE 200
BARBOURSVILLE, WV 25504
304-733-4616 FAX 304-733-4818
BRETT A. SHORT, D.C, DESTINY COOPER,D.C., ERIC COOOPER, D.C.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____