Short BACK TO HEALTH Chiropractic

Brett A. Short, D.C.
Eric Cooper, D.C.
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Patient Information

Child Name ___________________________________ Parent(s)/ Guardian Name _________________________________

Address _____________________________________ City __________________ State _________________ Zip ________

Home Phone _______________________ Work Phone ________________________ Cell Phone ______________________

Is it okay to contact you at work? Yes No

Email __________________________ Child's Social Security # ________________ Birthday ______________ Age ______

Have you or your child ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name ____

Were you pleased with your care? Yes No

How did you find out about our office? ____

Is this appointment related to auto accident? Yes No

Is your child receiving care from other health Professionals? Yes No

If yes, please name them and their specialty ____

Who is your family's primary care physician? ____

Please list any drugs or medications your child is taking ____

Please list any vitamins/herbs/homeopathic/other your child is taking ____

Please list any allergies your child has ____

CURRENT HEALTH

What health conditions bring your child to our office? ____

____

When did the symptoms first begin? ____

How did the problem start? Suddenly Gradually Post-injury

Is this condition Getting worse Improving Intermittent Not sure?

What makes the problem better? ____

What makes the problem worse? ____

Has your child ever had a similar condition? Yes No

Please explain: ____

Has your child been treated for this problem before: Yes No

Please explain: ____

Does your child eat well? Yes No Does your child have regular bowel/ bladder movements? Yes No

Has your child ever been checked for vertebral subluxations? Yes No Don't know

HEALTH HISTORY

Child's birth was: At home At a birthing center At a hospital

My obstetrician/midwife/family physician was ______________________________

Child's Birth was Natural vaginal (no medications/interventions)

Vaginal with interventions

Induction Pain medications Epidural Episiotomy Vacuum Extraction Forceps

Other ______________________________

C-Section

Scheduled Emergency

Please list reasons for any interventions/complications ______________________________

____

Child's birth weight ___________ Child's Birth height ___________ Current weight ___________ Current height ______

APGAR score at birth _____________ APGAR score after 5 minutes

GROWTH & DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? Yes No

If no, please explain ______________________________

At what age did the child:

Respond to sound ___________ Follow an object _____________ Hold head up ___________ Vocalize _______

Sit alone _____________ Teethe ______________ Crawl _____________ Walk _____________

Patient/Hospitalization/Surgical history (please list below all surgeries and Hospitalizations, including the year)

____

____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year ______________________________

____

Is/was your child breastfed? Yes No If yes, how long? _________________

Formula introduced at age _______________ What type? ______________________________

Introduction of cow's milk at age ______________________ Began solid food at age ________________________

Please list any food/juice intolerance ______________________________

Did Mother smoke during pregnancy? Yes No Did Mother drink alcohol during pregnancy? Yes No

Any illness of Mother during pregnancy? Yes No

If yes, Please explain including treatment/medications/supplements ______________________________

____

List any drugs/medications (including over the counter) taken during pregnancy ______________________________

____

List any supplements taken during pregnancy ____

Any exposures to ultrasound? Yes No If so, how many and what was the medical reason? __________

____

Any pets at home? Yes No Any smokers at home? Yes No

Has your child received any vaccinations? Yes No If yes, which ones and list any reactions _____________

____

Has your child received any antibiotics? Yes No If yes, please explain _____________________________

____

Any difficulty with breastfeeding? Yes No If yes, please explain ___________________________________

____

Any difficulty with bonding? Yes No If yes, please explain ____

____

Any behavioral problems? Yes No If yes, please explain ____

____

Any night terrors, sleepwalking or difficulty sleeping? Yes No If yes, please explain______________________

____

Age your child began daycare ____________________ Average number of hours of TV per week ________________

Does your child seem normal for their age? Yes No If no, please explain______________________________

____

FAMILY HISTORY REVIEW

Check those involved immediate family and add identification *M=Mother, F=Father, S=Siblings, G=Grandparents*

Cancer Type ___________ *M F S G*	Depression *M F S G*	Diabetes *M F S G*	Back Problems *M F S G*
Heart Disease *M F S G*	Liver Disease *M F S G*	High Blood Pressure *M F S G*	High Cholesterol *M F S G*
Lung Problems *M F S G*	Scoliosis *M F S G*	Neck Problems *M F S G*	Osteoporosis *M F S G*
Seizures *M F S G*	Osteoarthritis *M F S G*	Rheumatoid Arthritis *M F S G*	

Other ____

____

DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? Yes No Do any of your friends or relatives see a chiropractor? Yes No

If yes, do they use chiropractic for: Health maintenance/optimization Health problems Both

Are you seeking chiropractic for: Health maintenance/optimization Health problems Both

What would you like to gain from chiropractic care? ____

____

Are there other health concerns or anything else you'd like us to know about your child? ___________________________

____

INSURANCE COVERAGE INFORMATION

PRIMARY INSURANCE:

Insurance Carrier ____ Phone _____________________________

Policy Holder Name _______________________________ Policy Number __________________ Group Number _________

Insured Date of Birth _______ Insured Home # _______ Insured Work # _______ Relationship __Spouse __Child __Other

SECONDARY INSURANCE:

Insurance Carrier ____ Phone _____________________________

Policy Holder Name _______________________________ Policy Number __________________ Group Number _________

Insured Date of Birth _______ Insured Home # _______ Insured Work # _______ Relationship __Spouse __Child __Other

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

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 care as deemed necessary to my ________.

(Relationship)

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: ____ 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. (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. Erica 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: Lea 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: _____ / _____