

# Welcome

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Phone Numbers

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

## Accident Information

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## Patient Condition

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

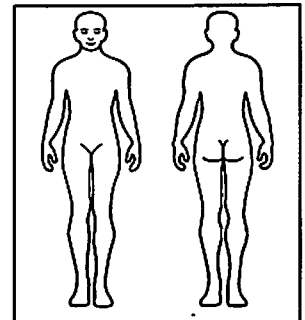
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# Health History

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine			Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
			Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

<p><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level
		Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

Chiropractic Wellness Center of Cary, PLLC  
Dr. Tammy Atkinson  
1155 Kildaire Farm Road, Suite 101, Cary, NC 27511  
Phone: (919) 439-2539

### NEW PATIENT HISTORY FORM

*Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.*

Symptom 1 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Symptom 2 \_\_\_\_\_

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:  
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  - Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day



1155 Kildaire Farm Rd, Ste 101, Cary, NC 27511

## **Group Health Insurance Office Policy**

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available. It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us, which will reduce your out-of-pocket expenses. In order to familiarize you with the financial policy of our office, we would like to explain how your health insurance will be handled.

1. Your insurance coverage will be verified, and the percentage of possible payment will be determined in an effort to help you determine exactly what chiropractic coverage is available under your policy. Please remember that is only a quote of percentage and all charges are considered at usual and customary fee schedules.
2. All deductibles and co-pays are expected at time of service or at the end of each week, and must be paid prior to insurance being submitted.
3. You are responsible for the patient's percentage and any difference that the insurance company does not cover.
4. Once insurance is billed and the insurance payment is received, if there is a balance due, you will be billed for the difference, which is your responsibility.
5. Chiropractic Wellness of Cary, PLLC, does not promise that an insurance company will pay for services that are usual and customary at this office, nor will this office enter into a dispute with an insurance company over reimbursement. This is the patient's obligation. We cannot alter or guarantee your insurance coverage.
6. Waiting for insurance payment is a courtesy to you, and may be withdrawn at any time.
7. Should you receive payment from the insurance company as a result of insurance formed submitted at this office, you will promptly submit such payment to this office within a week to cover any outstanding balance on your account.
8. Should your insurance reject, dispute, or not cover the total amount of charges submitted, you will pay for any outstanding balance within 30 days of verbal or written notification. It will be your responsibility to pursue reimbursement from the insurance company.
9. If forced to file with Small Claims Court or a collection agency to collect payment on services rendered, we will include all fees charged by the court, attorneys, or collection agency for services.
10. When making a health care decision, it is important to remember that you the patient are ultimately responsible for any services rendered.

If you have any questions, please do not hesitate to contact us. Please sign and date the underlined area after you fully understand the policy of health insurance.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



1155 Kildaire Farm Rd, Ste 101, Cary, NC 27511

## AUTHORIZATION TO FILE MEDICAL INSURANCE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy/Claim Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Who is Responsible for this Account? Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby give my permission to the office of Chiropractic Wellness Center of Cary, PLLC to file an insurance claim for my medical charges incurred at this office. I also request that payment be made directly to Chiropractic Wellness Center of Cary, PLLC.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Chiropractic Wellness Center of Cary, PLLC  
1155 Kildaire Farm Road, Suite, 101, Cary, NC 27511**

**NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**YOUR RIGHTS**

**Get an electronic or paper copy of your medical record**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

**ONLY** if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

**YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information

**In the case of fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you again.

**OUR USES AND DISCLOSURES**

**How do we typically use or share your health information? We typically use or share your health information in the following ways.**

- **Treat you**  
We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**  
We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**  
We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

For more information: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

**Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*Effective September 23, 2013*

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*Name*

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*Date*