

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance

Automobile Insurance Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____

Insured's Social Security #: _____ Employer's Phone #: _____

Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____

Date: _____

2. _____

Date: _____

3. _____

Date: _____

Have you ever had a metal implant? Yes No

Ever been gunshot? Yes No

ACCIDENT HISTORY : Job Auto Other 1. _____ Date: _____

Job Auto Other 2. _____ Date: _____

Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1 being least serious)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT Consistent
WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT
ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion constipation
- depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too heavy
- headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to colds
- muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in legs
- ringing in ears shortness of breath stiff neck stomach upset

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT FORM

I acknowledge that Laney Chiropractic Center's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Laney Chiropractic Center's Notice of Privacy Practices prior to signing this document. Laney Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Laney Chiropractic Center. The Notice of Privacy Practices for Laney Chiropractic Center's website at www.laneychiropractic.com. This Notice of Privacy Practices also describes my rights and Laney Chiropractic Center's duties with respect to my protected health information.

Laney Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Laney Chiropractic Center's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative (Print)

Description of Personal Representative's Authority

Name of Privacy Officer

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Laney Chiropractic Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent 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.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (Print)

Signature of Patient

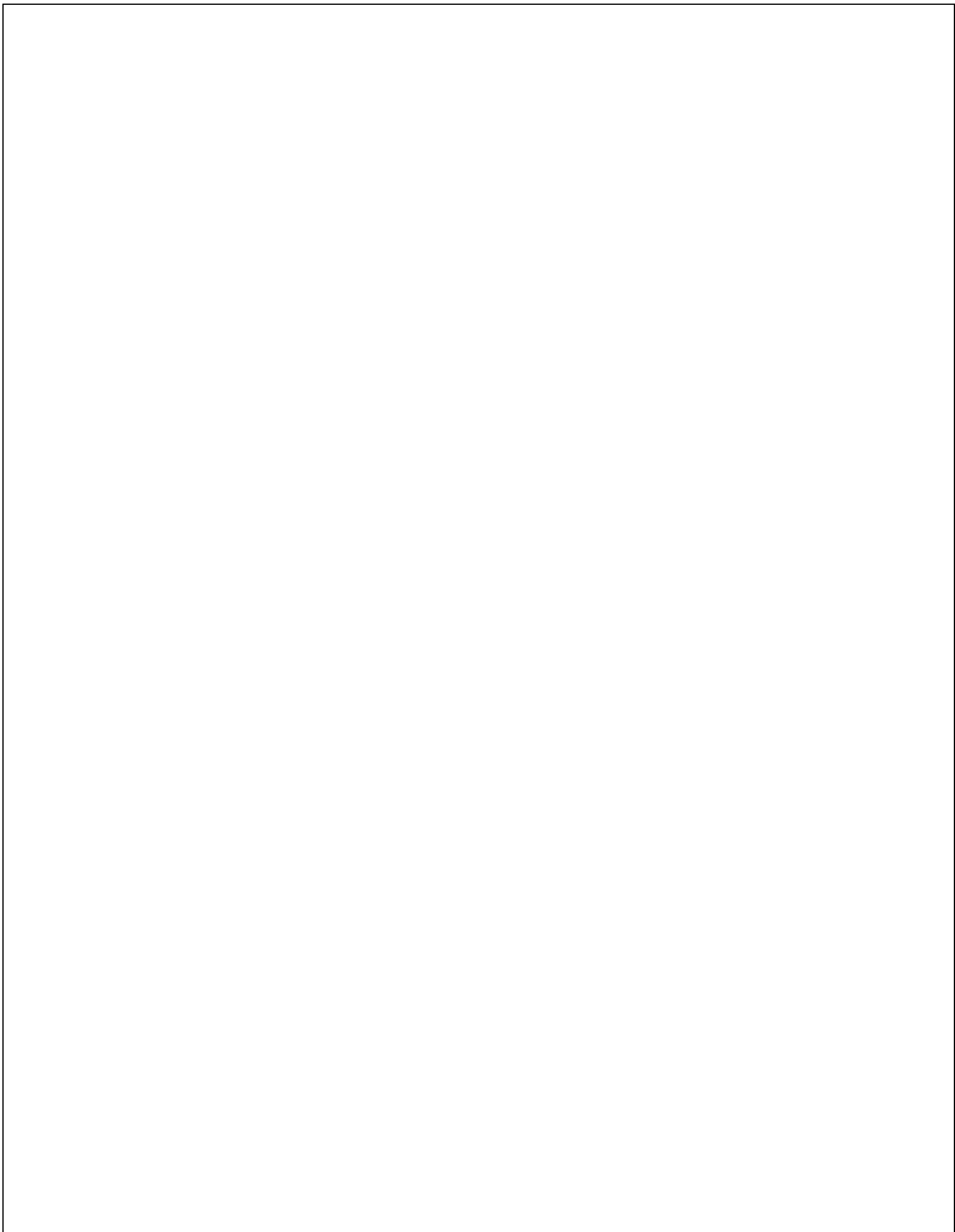
Date

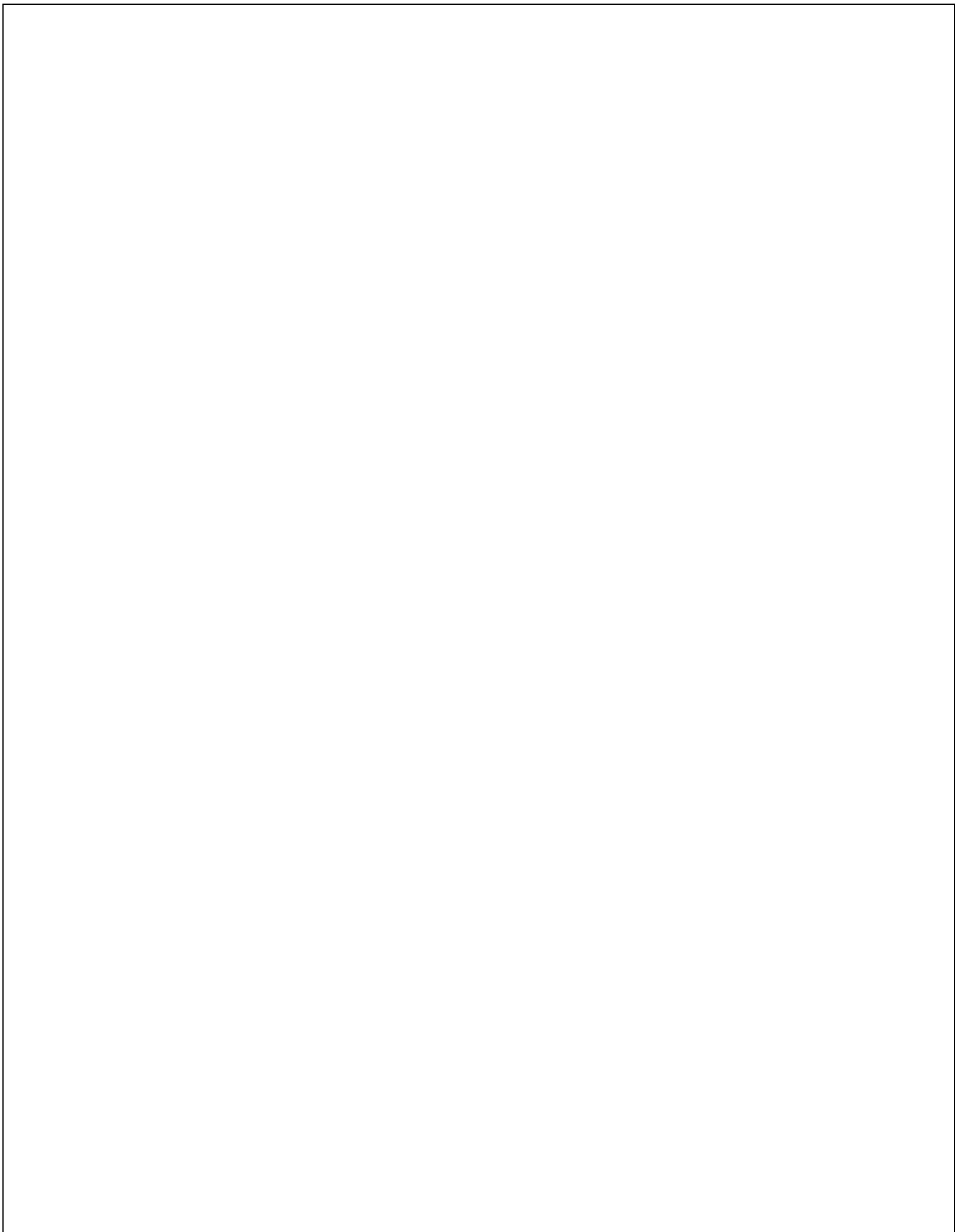
Signature of Patient Representative

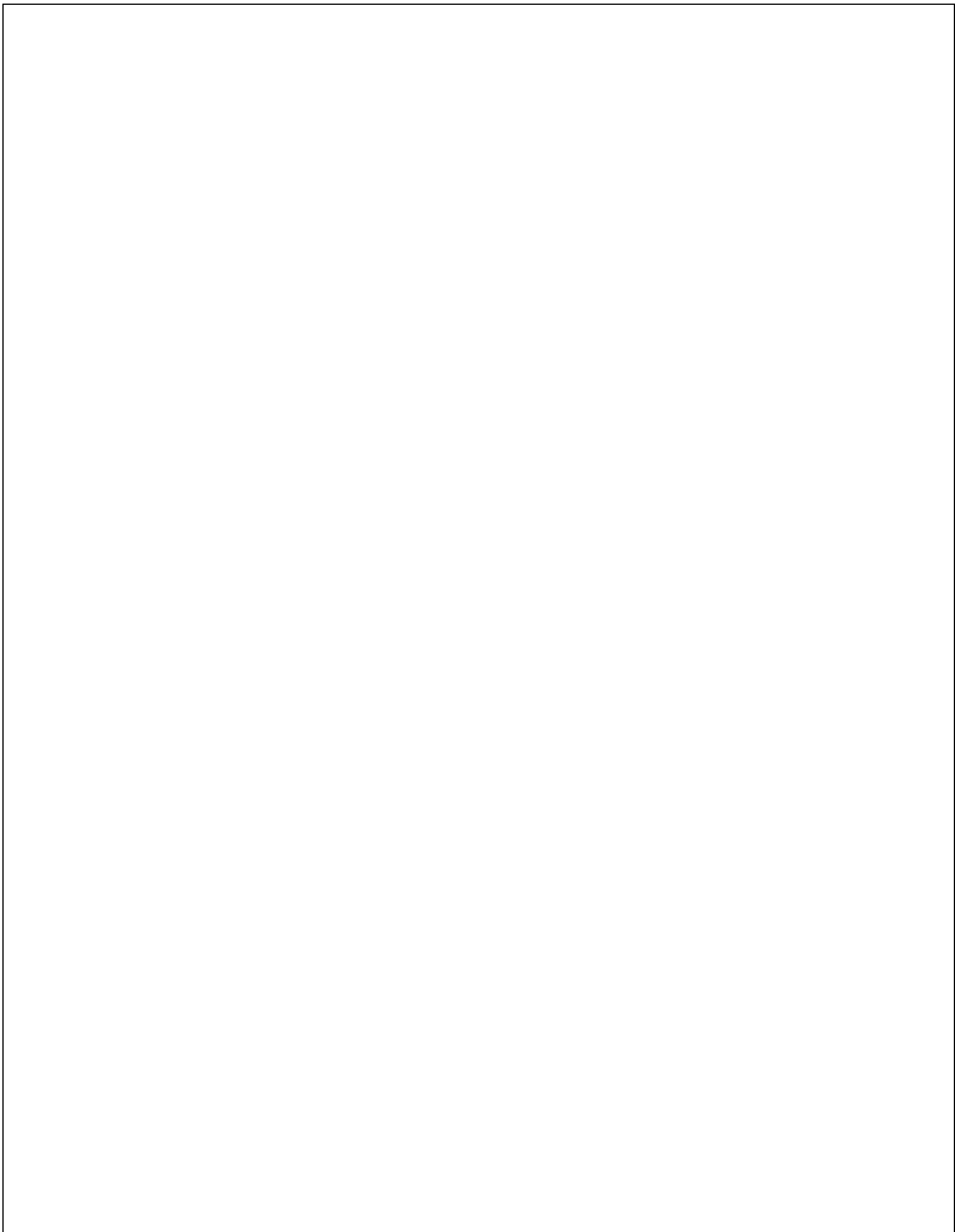
Relationship of Patient Representative to Patient

Office Representative

Date







INFORMED CONSENT DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing the statement of policy.

I have read and understand the foregoing.

DATE

SIGNATURE

**OFFICE POLICY ON FEES
AND INSURANCE CLAIMS**

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for that treatment. The insurance company has no relationship with the doctor. If we contact your insurance company and are informed that insurance benefits are available for the treatment recommended, we will file your claim for you. We are responsible only to file your claim and answer any medical questions they may have.

Insurance companies give estimates and benefits over the telephone, but they are only estimates and are not always accurate nor a guarantee of payment. You will be responsible for your yearly deductible and the portion of the charges your insurance carrier does not cover or lists as a "non covered" expense. We will file your insurance claims within one week of the date services are rendered. You will receive our regular billing as long as your account has a balance. This will keep you informed of the status of your account. If your insurance company does not pay within sixty (60) days, your bill is due and payable immediately.

_____ Name (please print)	_____ Date
_____ Signature of Responsible Party	

ASSIGNMENT AND RESPONSIBILITY

I hereby assign to Dr. Daryl G. Laney all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my insurance company. I further permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** If the insurance company does not pay within sixty (60) days, I understand the balance is due immediately and agree to pay in full.

_____ Signature of Responsible Party	_____ Date
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OUT OF NETWORK

I understand that Dr. Laney is not a preferred provider for my insurance company and that out of network insurance benefits will apply. This may include, but not be limited to, such things as a deductible, higher deductible, and/or higher co-pay, reduced benefits.

_____ Signature of Responsible Party	_____ Date
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