Corfman CHIROPRACTIC

ABOUT YOU

Today's Date: _____ File #: _____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ ❑ Male ❑ Female

Birth date: _____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone #: _____

E-Mail: _____

Referred By: _____

Employer: _____ How long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑Married ❑ Divorced
❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

Thank you for choosing us!

ACCOUNT INFO

Person ultimately responsible for account.

Name: _____

Relation: _____

Billing Address: _____

_____

SSN: _____ D.L.#: _____

Work phone #: _____ Home phone #: _____

I hereby authorize assignment of my insurance rights and benefits directly to Dr. Corfman for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible party signature

_____ _____
Relationship *Date*

INSURANCE INFO

Only fill out this section if you <u>have not</u> provided a copy of your insurance card to our front desk personnel.

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS #: _____

Group #: _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date:_____

IN EVENT OF EMERGENCY

Patient name

Date

Who should we contact? _____

Relation: _____

Home phone #: _____ Work phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Please list or provide our staff with a **complete list of all medications** that you are currently taking, including diet supplements and vitamins: _____

_____

Do you have or ever had any of the following diseases or conditions? (circle Y or N)

Y N Heart attack / Stroke	**Y N** Heart surgery / Pacemaker	**Y N** Heart murmur	**Y N** Polio
Y N Congenital heart defect	**Y N** Mitral valve prolapse	**Y N** Artificial valves	**Y N** Fibromyalgia
Y N Alcohol / Drug abuse	**Y N** Sexually transmitted disease	**Y N** Hepatitis	**Y N** Allergies
Y N HIV / AIDS	**Y N** Shingles	**Y N** Scoliosis	**Y N** Multiple Sclerosis
Y N Frequent neck pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia	**Y N** Thyroid trouble
Y N High / low blood pressure	**Y N** Mental / emotional difficulty	**Y N** Rheumatic fever	**Y N** Artificial bones / joints
Y N Severe / frequent headaches	**Y N** Kidney problems	**Y N** Ulcers / Colitis	**Y N** Difficulty breathing
Y N Fainting / Seizures / Epilepsy	**Y N** Sinus problems	**Y N** Asthma	**Y N** Diabetes / Tuberculosis

Y N Lower back problems

Y N Dislocated joint (please list): _____

Y N Arthritis (please list): _____

Y N Bone fracture (please list): _____

Y N Cancer (please list): _____

Y N Chemotherapy (please list): _____

Y N ANY disease or problem that can be passed from person to person

Please list any other serious medical condition(s) you have had: _____

_____

Please list anything that you may be allergic to, including medications: _____

_____

List previous surgeries / treatments with dates: _____

_____

List any past auto accidents, falls or sports injuries, with dates: _____

_____

Family health history (cancer, heart disease, high blood pressure, or any other problem that runs in your family):

_____

_____

Are you wearing: ❑Heel lifts ❑Sole lifts ❑Inner soles ❑Arch supports

What is the age of your mattress? _____ years Is it comfortable? ❑Yes ❑No

For Women: Are you taking birth control? ❑Yes ❑No

Are you pregnant? ❑Yes ❑No How far along? _____ Nursing? ❑Yes ❑No

REASON FOR VISIT

Patient name

Date

Doctor's Notes:

What is your chief complaint? _____

Please describe the pain and its location: _____

_____

When did your condition begin? _____

This visit is a result of (please circle): WORK, SPORTS, AUTO ACCIDENT, OTHER TRAUMA or CHRONIC

Please describe what happened: _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Activities that are painful: ❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying down ❑ work ❑ sleep

❑ daily routine ❑ recreation ❑ certain movements ❑coughing ❑ driving

Please describe anything else that makes your pain worse: _____

_____

What has helped ease your pain? (example: ice, heat, medications, exercises). Please describe:

_____

Is the pain: ❑ Constant (75-100% of the time) ❑ Frequent (50-75% of the time)

❑ Intermittent (25-50% of the time) ❑ Occasional (10-25% of the time)

❑ Rare (less than 10% of the time)

Is this condition interfering with your (please circle): WORK, SLEEP, or DAILY ROUTINE?

If so, please explain: _____

Please describe any previous care you have had for this condition: _____

_____

Have you been treated by a Medical Doctor for this condition? ❑ Yes ❑ No

If so, when and where? _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

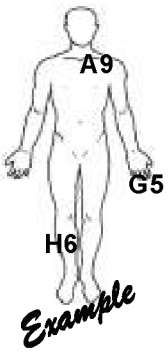
If so, please explain: _____

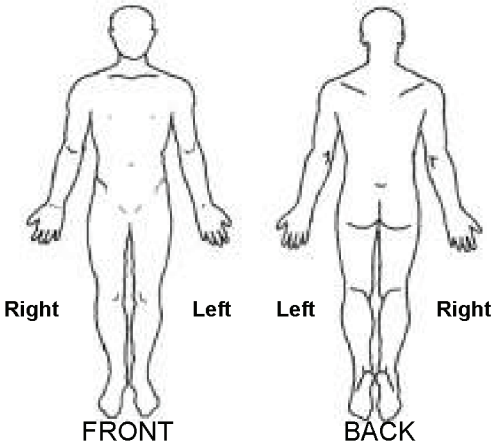
Have you ever been treated by a Doctor of Chiropractic? ❑ Yes ❑ No

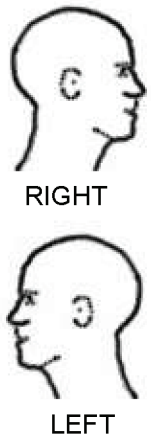
If so, whom? _____ Phone #: _____

Please mark areas of injury or discomfort using the symbols at the left of the page as shown in the example below. Please mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (least pain) to 10 (severe pain).

A ..... Aching
B ..... Burning
C ..... Cramping
D ..... Dull
E ..... Sharp
F ..... Stiffness
G ..... Numbness
H ..... Shooting
I ..... Throbbing
J ..... Tingling







Corfman CHIROPRACTIC

Patient name

Date

SYSTEMS REVIEW

Are you presently suffering (or within the past 6 months suffered) from any of the following:

GENERAL ❑ Normal
❑ Weakness ❑ Fever
❑ Chills ❑ Night sweats
❑ Weight loss ❑ Other _____

EYES ❑ Normal
Vision trouble …… ❑ Right ❑ Left
Pain …… ❑ Right ❑ Left
Discharge …… ❑ Right ❑ Left
Other …… ❑ Right ❑ Left

NOSE ❑ Normal
❑ Pain ❑ Absence of smell
❑ Bleeding ❑ Other _____

PSYCHOLOGIC ❑ Normal
❑ Anxiety ❑ Depression
❑ Phobias ❑ Mood swings
❑ Memory loss / impairment
❑ Other _____

GENITOURINARY ❑ Normal
❑ Inability to hold urine ❑ Frequent urination
❑ Painful urination ❑ Painful menstruation
❑ Irregular menstruation ❑ Abnormal vaginal bleeding
❑ Other _____

CARDIO-VASCULAR-PULMONARY ❑ Normal
❑ Cough ❑ Wheezing
❑ Murmur ❑ Difficulty breathing
❑ Chest pain ❑ Swollen extremities
❑ Palpitations ❑ Blue extremities
❑ Other _____

WOMEN ONLY: ❑ Normal
❑ Breast pain ❑ Lumps in breast
❑ Breast dimpling ❑ Breast redness / itching
❑ Breast discharge ❑ Other _____

SKIN ❑ Normal
❑ Rash ❑ Redness
❑ Itching ❑ Eczema
❑ Hair changes ❑ Nail changes
❑ Other _____

EARS ❑ Normal
Hearing trouble …… ❑ Right ❑ Left
Ringing …… ❑ Right ❑ Left
Pain …… ❑ Right ❑ Left
Discharge …… ❑ Right ❑ Left
❑ Other _____

ENDOCRINE ❑ Normal
❑ Sugar in urine ❑ Goiter
❑ Heat / cold intolerance ❑ Tremor
❑ Other _____

NEUROLOGIC ❑ Normal
❑ Headache ❑ Dizziness
❑ Fainting ❑ Convulsions
❑ Other _____

MOUTH / THROAT ❑ Normal
❑ Bleeding ❑ Sores
❑ Absence of taste ❑ Abnormal taste
❑ Other _____

GASTROINTESTINAL ❑ Normal
❑Decreased appetite ❑ Increased appetite
❑ Vomiting ❑ Diarrhea
❑ Constipation ❑ Abdominal pain
❑ Other _____

Now that you have completed your paperwork, please give our staff a few minutes to compile your chart. Dr. Corfman will review your paperwork and sit down to talk with you about your problem very soon. Again, thank you for choosing our office. We look forward to helping you with your problem.

FINANCIAL OFFICE POLICY
CORFMAN CHIROPRACTIC & REHAB

1. This office accepts Discover, MasterCard, Visa, cash and personal checks.
2. If your deductible has not been met, all charges are your responsibility and are due when services are rendered. At such time when your deductible has been met, then your co-pay for your visit and any therapy that you receive is due at the time of your visit.
3. Waiting for payment from your insurance company is a courtesy and may be withdrawn under certain circumstances.
4. As a patient, it is responsibility to take care of the co-payment (usually 20%) and any non-covered services at the time of your visit. Our office may make payment arrangements on an individual basis. At such plan or arrangement will be discussed with our Office Manager.
5. This office does not warrant or guarantee that your insurance will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and you, the patient.
6. Any services not covered or coverage reductions by your insurance will be your responsibility.
7. This office will resubmit a claim **one time.** We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as non-covered services and you will be expected to pay such charges in a timely manner.
8. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only **after your balance is completely cleared with this office**.
9. If you receive any correspondence or payment from your insurance company, you hereby agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.
10. If you are referred to another specialist or discontinue care for any reason other than discharge by Dr. Corfman, your account becomes due and payable in full immediately, regardless of any claims submitted.
11. If you change insurance companies or employers, you agree to provide this office with current information immediately.
12. If you have questions regarding this or any other matter, please speak with the receptionist of our insurance department prior to seeing Dr. Corfman.

Thank you.

I have read and understand the Financial Policy and agree to abide by these terms.

_____

Patient Signature Date

_____

Witness Date

Charles G. Corfman, D.C.
2530 Florence Blvd. · Florence, AL 35630 · 256-767-9900

Corfman
CHIROPRACTIC

2530 Florence Blvd. Suite C
Florence, AL 35630
256-767-9900

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____ _____

Date Initials

_____

Reason

CONSENT FOR TREATMENT:

Corfman CHIROPRACTIC

I, _____ (PRINT), do hereby authorize Dr. Charles Corfman and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. **I ALSO CERTIFY THAT IN NO WAY HAVE ANY GUARANTEE OR ASSURANCES BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.** I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

Patient/Guardian:
Name Printed: _____
Name Signed: _____ Date: _____
Witness:
Name Signed: _____ Date: _____

CONSENT FOR TREATMENT OF A MINOR:

I hereby authorize Dr. Charles Corfman and whomever he may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as they deem necessary to_____, a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

Patient/Guardian:
Name Printed: _____
Name Signed: _____ Date: _____
Witness:
Name Printed: _____
Name Signed: _____ Date: _____

Today's Date: ___/ ___/ ___

ASSIGNMENT OF BENEFITS:

I hereby authorize the following insurance companies or liable direct pay parties:

1. _____
2. _____
3. _____
4. _____

To pay by check or credit card through either mailing the check payable to either Dr. Charles Corfman at 2530 Florence Blvd. Suite C, Florence, AL 35630. This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state that this office is given a **limited power of attorney to endorse/sign my name on any and all drafts directed for the payment of my bill.**

Patient:
Name Printed: _____
Name signed: _____ Date: _____

Witness:
Name Printed: _____
Name Signed: _____ Date: _____