Anthem Chiropractic
Family Practice • Injuries • Wellness
Happy Spine, Healthy Life
Dr. Derek Day, D.C.
10170 S. Eastern Ave. #110 Henderson, NV 89052 (702) 614.6777 fax (702) 614.6778
Website: www.drderekday.com Email: drday1@lvcoxmail.com

PATIENT INFORMATION:

Name: _____Date: _____

Date of Birth: _____ Height _____ Weight _____ Dominant Hand: (R) (L)

Address:_____City/State:_____Zip: _____

Phone: (cell)_____ Other: _____

Email: _____ Driver's License#: _____

Sex: (M) (F) Circle: Single/ Married/ Widowed/ Minor/ Separated/ Divorced/ Partnered

Employer/School: _____

Address:_____City/State:_____Zip: _____

Employer/School Phone: _____Occupation: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer:_____ Phone#: _____

In Case of Emergency: _____ Phone#: _____

Relationship to patient: _____

Who is responsible for this account: _____Relationship: _____

Health Ins. Co.: _____

Group#: _____ Member ID#: _____

Is patient covered by additional insurance? (Y) (N) Health Ins. Co: _____

Name of Insured: _____ Phone#: _____

Date of birth: _____SS#: _____ Relationship to patient:_____

Group#: _____ Member ID#: _____

Was this condition due to an Auto Collision? (Y) (N)

Who is your family doctor? _____

How did you hear about our office? __Internet __Ins. __ Dr: _____ Patient: _____

PATIENT CONDITION:

Reason for visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? (Y) (N)
Rate the severity of your pain on a scale from mild / moderate /severe (circle one)
Type of pain: (circle one) Sharp/Dull/Throbbing/Numbness/Aching/Shooting/Burning/ Tingling/Cramps/ Stiffness/Swelling/ Other _____
Does it interfere with your: Work/ Sleep/ Daily Routine/ Recreation (circle one)

Activities or movement that is painful to perform: sitting/standing/walking/bending/laying down

How often do you have pain? _____

Is your pain constant or does it come and go? _____

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HEALTH HISTORY: (prior to accident)

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: _____

Please check to indicate if YOU HAVE HAD the following:

___ AIDS/HIV
___Alcoholism
___Allergy Shots
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorders
___Breast Lumps
___Bronchitis
___Bulimia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___ Fibromyalgia
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disc
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Liver Disease
___Lupus
___Migraine/Headaches
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Osteoporosis
___Osteopenia
___Pacemaker
___Parkinson's Disease
___Pneumonia
___Polio
___Prosthesis
___Psychiatric Care
___Rheumatoid Arthritis
___Rheumatic Fever
___STD
___Stroke
___Suicide Attempts
___Thyroid Problems
___Tonsillitis
___Typhoid Fever
___Ulcers
___Vaginal Infections
___ Whooping Coughs
___ Other:_____
_____

Are you pregnant? ___ Yes ___ No ___ Due Date: _____
Exercise: ___ None ___Moderate ___Daily ___Heavy
Work Activities: ___Sitting ___Standing ___Light Labor ___Heavy Labor

Habits: ___Smoking: Packs/Day: _____ ___Alcohol: Drinks/Week: _____

___Coffee/Caffeine: Cups/Daily: _____ ___High Stress Level Reason:_____

Falls: __ Yes __No When: _____
Describe:_____
Head Injuries/Concussion: __ Yes __ No When: _____
Describe:_____
Broken Bones: __Yes __ No When: _____
Describe:_____
Dislocations: __ Yes __ No When: _____
Describe:_____
Auto Injuries/Work Injuries: __Yes __No When: _____
Describe:_____
Prior Neck/Back Surgeries: __ Yes __ No When: _____
Describe:_____
Other Surgeries: __Yes __ No When: _____
Describe:_____

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Please read, sign last page, & keep first 2 pages for your records.

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.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used by staff members to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day to day activities and management of Anthem Chiropractic. For example, information on the services being provided may be used to support budgeting and financial reporting, and activities to evaluate and promote quality, such as training. In addition, we may also use a sign in sheet where you will be asked to provide your name and indicate your physician. We may also call your name in the waiting room when your physician is ready to see you.

Law Enforcement: Your health information may be disclosed to public health agencies to support government audits and inspections, to facilitate law enforcement investigations, and comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: Your health information may be used by our staff to send you appointment reminders.

Information about Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

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INDIVIDUAL RIGHTS

You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Anthem Chiropractic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices and policies. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or Office Manager. You request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Attn: Privacy Officer
Anthem Chiropractic
10170 S. Eastern Avenue Ste 110
Henderson, NV 89052

If you feel that your privacy rights have been violated, please call the matter to our attention by sending a letter to the above listed address.
** You will not be penalized or otherwise retaliated against for filing a complaint**

Contact Person

For any further information concerning our privacy practices please contact us at:

Attn: Office Administrator
Anthem Chiropractic
10170 S. Eastern Avenue Ste 110
Henderson, NV 89052
(702) 614-6777

Anthem Chiropractic reserves the right to modify the privacy practices outlined in the notice.

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I have received a copy of the Notice of Privacy Practices for Anthem Chiropractic.

_____

Printed Name of Patient **Date**

_____

Signature of Patient **Date**

_____

Signature of Patient Representative **Relationship**

****Required if the patient is a minor or an adult who is unable to sign this form****

*********************************For Office Use Only*********************************

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- **The patient was undergoing emergency treatment**
- **The patient declined to sign the acknowledgement**
- **Other**

_____

Name of Patient (Print)

_____

Name of Staff Member **Date**

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INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the Doctor and/ or with other office or clinic personnel, the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Various medical procedures will be reviewed and a referral will be provided if deemed medically necessary.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to: fractures, disc injuries, strokes, bruising, dislocations, and sprains.

I understand that I may be receiving the following treatment:

HOT/COLD THERAPY, MINERAL ICE, ULTRASOUND, EMS, MANUAL/ FLEXION TRACTION, TRIGGER POINT THERAPY, VIBRATORY/ DEEP TISSUE MASSAGE, TENS, THERAPEUTIC EXERCISES, LIFESTYLE AND ERGONOMIC INSTRUCTIONS, SPINAL ADJUSTMENTS/ JOINT MOBILIZATION TECHNIQUES, POSTURAL CORRECTION, NUTRITIONAL SUPPLEMENTATION AND DIETARY RECOMMENDATIONS.

I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient: _____

Date: _____

Signature of Parent/ Guardian: _____ Date: _____
Required if the patient is a minor or an adult who is unable to sign this form

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FINANCIAL AND INSURANCE ASSIGNMENT POLICY

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. Since by taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
2. Network vs. Out of Network: If your carrier has a "network" of providers, it is your responsibility to make sure we are in network. We can provide "out of network" care but you portion maybe higher. It is your responsibility to make sure your insurance carrier and billing information is accurate.
3. Your insurance should pay within 30 days. If you're insurance has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company, when and if it pays. There will be an interest charge of 7% per annum (year) charged on all unpaid balances over 60 days.
4. We will bill your insurance on a weekly basis as long as you are receiving Chiropractic care in this office. Cash patients will pay on the date of service per our time of service fee schedule.
5. If you choose you may pay a percentage of your responsibility as you go along until the insurance check is received. We will verify your co-insurance portion prior to treatment. This office accepts cash, check or bankcard as payment.
6. Or we will bill your insurance company weekly and when we receive an insurance check, we will bill you for any balance and or interest due at the time.
7. You are required to sign an "Assignment to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.
8. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied you are responsible for the full amount of your bill.
9. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
10. All special arrangements regarding finances must be signed by the Doctor and Patient and/or other representative.
11. Auto injury policy – For auto policies we bill the primary medical payment/PIP. If your care exceeds your coverage limit, we may be able to bill your health insurance or put you on our time of service plan. If you are represented by an attorney, you must sign a doctor's lien that will be forwarded to your lawyer. Please be advised that you are responsible for your bill regardless of the circumstances. Third party insurance will not reimburse our office directly; therefor third party insurance will NOT be billed.
12. Returned checks – You will be charged $25.00 for a returned check.
13. Medical records – You may request a copy of your medical records. We charge $0.60 per page when you pick them up.

If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment. I hereby authorize my insurance benefits to be paid directly to said doctor. I am responsible for balance due and authorize doctor or insurance co. to release my personal information to pay this claim.

(___) I wish to **NOT** utilize my health insurance coverage and choose to be a Cash Patient.

_____ _____

Signature of Patient/Guardian Date

_____

Print Patient Name

Anthem Chiropractic
Family Practice • Injuries • Wellness

Dr. Derek Day, D.C.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name (Printed):_____

Date of Birth: _____ **Social Security Number:**_____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Anthem Chiropractic.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to Anthem Chiropractic.

I hereby designate the above named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

_____	_____
Provider Name	Phone
_____	_____
Provider Name	Phone
_____	_____
Provider Name	Phone

Please send records to: **Anthem Chiropractic**
10170 S Eastern Ave., Ste. 110
Henderson, NV 89052
Phone: 702.614.6777
Fax: 702.614.6778

_____

Signature of Patient or Legal Representative Relationship to Patient **Date**

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MISSED APPOINTMENT POLICY

In an effort to avoid missed appointments, you will receive an automated reminder call and/or text message confirmation from our office the evening before your scheduled appointment.

Our office policy regarding missed appointments is as follows:

Any appointment cancelled with less than 24 hours' notice, including "no call- no shows", will be billed as a missed appointment. The missed appointment fee of $25.00 must be paid prior to / or at the time of your next appointment. This amount is not eligible for insurance billing and is the responsibility of the patient.

Thank you for your understanding and consideration,

Dr. Day and Your Anthem Chiropractic Team

I HAVE READ AND UNDERSTAND THE ABOVE DESCRIBED MISSED APPOINTMENT POLICY. I WILL BE RESPONSIBLE FOR ALL APPOINTMENTS NOT CANCELLED WITH 24 HOURS NOTICE, INCLUDING NO CALL- NO SHOW APPOINTMENTS. THIS WILL RESULT IN A $25.00 FEE NOT BILLABLE TO MY INSURANCE, WHICH MUST BE PAID ON OR BEFORE MY NEXT APPOINTMENT DATE.

_____ _____

Patient Signature Date

_____

Patient Name (Please Print)