



Chiropractic Partners
Dr. Brook S. Wallace
7629 Purfoy Road, Suite 109
Fuquay-Varina, North Carolina 27526
(919)-577-0660-Telephone (919)-577-2286-Fax

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name Last _____ First _____ MI _____ SS# _____ - _____ - _____

Address _____ City/State _____ Zip Code _____

Birth Date ____/____/____ Home Phone _____ Cell Phone _____ Marital M S W D

Employer _____ Occupation _____

Employer Address _____ Phone# _____

Emergency Contact Name _____ Relationship _____ Phone _____

Describe in *detail* the reason for your visit today

How did you hear about us? _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of auto or other accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or similar condition? Yes ___ No ___ If yes, when and describe

Have you ever seen a chiropractor? Yes ___ No ___ Who is your medical doctor? _____

Date of your last examination _____ What operations have you had & when _____

Serious illnesses? _____ When? _____

- | | | | | |
|--|------------------------------------|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Back Aches | <input type="checkbox"/> Headache | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Neck Aches | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High or Low Blood Pressure | |

What medications or drugs are you taking? _____

Other doctors seen for this condition _____

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

Describe _____

HEALTH INSURANCE Yes ___ No ___

Company _____ ID# _____ Group# _____

Cardholders DOB _____ **Cardholders** Employer _____

Patients Signature _____ Date _____



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STATEMENT OF FINANCIAL OBLIGATIONS

As a courtesy, we accept insurance on assignment, upon verification of your benefits and coverage. We gladly file all claims for service, according to our policies, directly to your insurance carrier.

- You will be responsible for any/all deductibles, co-insurance/payments, and non-covered benefits, which we will gladly provide several options to help you take care of these out of pocket expenses.
- We will do our best to accurately file our claims; however, we cannot be responsible for how your insurance company chooses to reimburse for your care.
- Should your carrier deny any claims for service, we will provide the necessary documents for a valid appeal or reconsideration. However, if this endeavor is not successful, you will be responsible for your account balance, and we will be glad to provide you with available payment options at said time. You will be responsible for the pursuit of reimbursement directly from your insurance company.
- If your care requires an authorization from your Primary Care Physician or Insurance carrier, we will do our best to maintain this authorization for treatment. However, it is your responsibility to take an active role in the authorization process, and stay updated on their dates of expiration. We will not assume the responsibility for any unauthorized treatment. Your involvement always ensures a better chance of obtaining full coverage.
- Although insurance coverage varies depending on individual contracts and plans, we find that most plans do not provide coverage or benefits for the following, therefore, payment in full will be required at the time services are rendered:
 - Rehabilitative, maintenance, or chiropractic wellness care
 - Supports, braces, cervical pillows, and most supplies
 - Supplements

We will gladly submit all services rendered, but should your insurance company deem them a non-covered benefit and deny payment, you will be responsible for any full, unpaid amount of submitted services.

With my signature below, I confirm that I have been informed of and understand the terms and policies as outlined above. I agree to be responsible for payment and insurance processing for any non-covered services listed above, and to make payment arrangements for my estimated financial responsibility.

Patient Signature
(Parent or guardian if patient is a minor)

Date

Print Name



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Authorization for Disclosure of Health Information and for Direct Contact

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Disclosures of Protected Health Information

There are several reasons for which we have to use or disclose your PHI (Protected Health Information);

- We may have to disclose your PHI to another healthcare provider or hospital should we refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and/or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to use at any time. Again, this change of authorization is requested in writing before your file status will be changed.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520).

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow-up of health care, insurance coverage's/benefits issues, or any other information that only the patient will personally be able to answer.

I wish to be contacted in the follow manner (check any/all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Work Telephone _____ |
| <input type="checkbox"/> Ok to leave message with detailed information | <input type="checkbox"/> Ok to leave message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Leave message with call-back number only |
| <input type="checkbox"/> Written Communication | <input type="checkbox"/> Cell Phone _____ |
| <input type="checkbox"/> Ok to mail to home address | <input type="checkbox"/> Ok to leave message with detailed information |
| <input type="checkbox"/> Ok to mail to my work/office address | <input type="checkbox"/> Leave message with call-back number only |
| <input type="checkbox"/> Ok to fax to this number _____ | |
| <input type="checkbox"/> E-mail _____ | |
| <input type="checkbox"/> Other _____ | |

Patient Signature

Date

Print Name

Date of Birth