# Bratcher Chiropractic

Dr. Luther B Bratcher, D.C.
Dr. William X Bratcher, D.C.

## CONFIDENTIAL PATIENT INFORMATION

Date_____

Full Name: _____ Social Security: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Office Phone: _____ Contact Preference: ____ Work ____ Home ____ Cell ____ Email

Date of Birth: _____ Age: _____ Male: _____ Female _____ Marital Status: M S W D

Who does the patient reside with: _____

Spouses Name: _____ How many children do you have? _____

Employer:_____ Job Title:_____

How were you referred to our office? _____

Language: ____ English ____ Spanish ____ Indian ____ Japanese ____ Chinese ____ Korean ____ French ____ German ____ Russian ____ Other

Race: ____ White ____ African American ____ Asian ____ American Indian or Alaska Native ____ Native Hawaiian or other Pacific Islander ____ Decline to specify

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic of Latino ____ Decline to answer ____ Unknown

Family Medical Doctor: _____

Would you like us to send your family Medical Doctor a copy of today's visit? Yes No

How can we best serve you?

1. _____ Get rid of the symptoms only.
2. _____ Get rid of the symptoms, but then fix the problem so that it doesn't come back.
3. _____ Get rid of the symptoms, fix the problem, and also talk to me about exercise, supplements and nutrition so that I can be as healthy as possible and get the most out of my life.

## HISTORY OF PRESENT ILLNESS

Chief Complaint:_____

How did it originally occur? _____

Is this due to: ____ Auto ____ Work ____ Other

Has it become worse recently? ____ Yes ____ No ____ Same ____ Better ____ Gradually Worse

What date did the symptoms occur or the accident happened: _____

How frequent is the condition? ____ Constant ____ Daily ____ Intermittent ____ Night Only

Describe the pain: ____ Sharp ____ Dull ____ Numbness ____ Tingling ____ Aching ____ Burning ____ Stabbing ____Other_____

Is there anything you can do to relieve the problem? Yes No

If yes, please describe:
_____

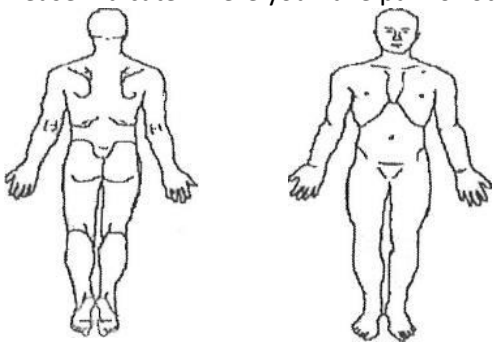
What makes the problem worse? ____ Standing ____ Sitting ____ Walking ____ Bending ____ Lifting ____ Twisting ____ Other_____

Have you ever had the same or similar condition? Yes No

If yes, when and describe: _____

Have you ever been to a chiropractor? Yes No

Please indicate where you have pain or other symptoms:



**Women Only**:
Are you pregnant or is there a possibility you may be pregnant? Yes No
If yes, how far along are you in your pregnancy?
_____

## PAST MEDICAL HISTORY

Have you ever been diagnosed with: ___ High Blood Pressure ___ Stroke___ Diabetes (___ Type 1 ___ Type 2)

Please list any surgeries (Women only: Please include anything in regards to childbirth if it applies)
_____

Please list any major illness, injuries, falls, or auto accidents?
_____

Please list any health conditions you have been treated for within the last year:
_____

What medications or drugs are you taking?

_____

Please list any allergies:

_____

Have you ever been diagnosed as having or suffering from (Check all that apply):

**General**

___ Fatigue ___ Weakness ___ Fever ___ Chills ___ Weight Change ___ Night Sweats

**Neurologic**

___ Fainting ___ Headache ___ Dizziness ___ Convulsions

**Eyes**

___ Vision Trouble ___ Pain ___ Discharge

**Heart/Lungs**

___ Blue Extremities ___ Murmur ___ Chest Pain ___ Palpitations ___ Difficulty Breathing ___ Swollen Extremities

**Stomach/Intestines**

___ Decreased/Increased Appetite ___ Abdominal Pain ___ Vomiting ___ Diarrhea ___ Constipation

**Mental**

___ Anxiety ___ Depression ___ Memory Loss or Impairment ___ Phobias ___ Mood Swings

## SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No If yes, how much per week? _____

Do you smoke? ___ Never ___ Former Smoker ___ Current Every Day ___ Current Some Day

Please list any vitamins or supplements:_____

Do you consume caffeine? Yes No If so, how much per day? _____

How often do you exercise and what type: _____

Do you use recreational drugs? Yes No

## FAMILY HISTORY

Family diseases (Indicate all that apply, please mark which side. Ex. Mother, Father, Brother, Sister)

____ Cancer ____ Mental Illness ____Diabetes ____ Heart Disease ____Stroke ____ Arthritis
____Other:_____

**Thank you for taking the time to complete this form. We look forward to helping you reach your health goals.**

# Authorization:

A: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment.

B: I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited in my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or products or professional services rendered will be immediately due and payable.

**Acknowledgement for 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 Bratcher Injury & Wellness Center, P.A. 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**

Your 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.

_____

Printed name of Patient

_____

Signature of Patient or Patient Representative Date

_____

Bratcher Injury & Wellness Center, P.A.

**HIPAA Alternative Access Form**

**Patient Name**_____ **Date of Birth** _____

## Release of Information

**I authorize the release of confidential communication of protected health information to be given to the following person/persons.**

Name/relationship_____ Phone_____

Name/relationship_____ Phone_____

Name/relationship_____ Phone_____

Name/relationship_____Phone_____

*The **Release of Information** will remain in effect until terminated by me in writing.

## Messages

If unable to reach me you may:

_____ Leave a message requesting a return call only
_____ Leave a detailed message
_____ Do not leave a message
____ Other:_____

_____ _____

**Signature of Patient or Patient Representative** **Date**

## Acknowledgement of Review of Notice of Privacy Practices

I am aware of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Printed Patient Name Date of Birth

_____ _____

Representative's Authority Office Employee Signature

***If refusal to sign please state reason and document patient received a copy of the policy.**

_____
_____
_____

_____ _____

Office Employee Signature Date

# Bratcher Injury & Wellness Center, P.A.

**Appointments:** It is very important that your make every effort to keep your appointment. We try our best to allocate the proper amount of time for each patient. If you are unable to keep your scheduled appointment, please call to cancel so that we may open that time slot for another patient.

**Insurances:** We accept assignment of benefits for most insurance carriers and other health plans, because of this it is crucial to provide us with the correct insurance information. We will bill those insurance plans whom we have an agreement. ***Copayments and deductibles are due at the time the services are rendered.*** If your insurance changes it is your responsibility to inform our office. Please be aware that some of the services we provide may not be covered by your carrier and may not be considered reasonable and/or necessary under the Medicare program and/or other medical insurances; thus reimbursement is fully your responsibility.

**Private Pay Patients:** Patients without health insurance will be charged a "time of service fee" and is required to be paid the same day services are rendered.

**Usual and Customary or Not Covered:** We charge what is usual and customary for our area. You are responsible for payment in full of any non-covered service regardless of an insurance company's arbitrary determination of usual and customary rates.

**Regarding Referrals:** If your insurance company requires a referral from you primary care physician (PCP) it is your responsibility to make sure our office has received it and that it is correct or you will be responsible for the complete charge.

**Dependent Patients:** For all services rendered to a dependent patient, we will request the parent and/or guardian to be responsible for all payments.

**Medical Records Requests:** Patients will be able to receive one copy at no charge, however any additional copies the medical record fee will apply.

**Billing Inquiries:** Please contact our office directly regarding any billing questions. If your account has been entered into collections you will need to contact the collection agency regarding your account status.

**Attorney/LOP:** We do accept LOP cases on a case by case basis. If for any reason your attorney releases your case you will be responsible for the full balance incurred.

**Collections:** When there is an unpaid balance due on your account we will send out two statements. If payment is not made on the account within 90 days it has the possibility to be sent to an outside collections agency and a surcharge will be added to your unpaid balance.

Thank you for taking the time to read our financial policy. Please let us know if you have any questions or concerns as we want you to fully understand our policy.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Printed name of Patient Date of Birth

# Informed Consent

Bratcher Injury and Wellness Center P.A.
Bratcher Chiropractic Diagnostic Center, P.C.
Tyler Sports & Industrial Rehab Center
Dr. Luther B Bratcher, DC
Dr. William X Bratcher, DC

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____