Dr. Charles E. Copeland, DC ♦ Highland Chiropractic

Name: _____
Birth Date: ____/_____/_____ Gender M / F
Address: _____
City: _____ State: _____ Zip: _____

Occupation: _____
Employer: _____
How did you hear about us?
_____

Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
E-mail Address: _____

Preferred Phone to Contact
☐ Home ☐ Work ☐ Cell
Preferred Method of Contact
☐ Phone ☐ Mail ☐ Email

Race – check one

☐ American Indian / Alaska Native
☐ Asian
☐ Black / African American
☐ More than one race
☐ Native Hawaiian
☐ Pacific Islander
☐ White
☐ Unreported / Refused to Report

Ethnicity – check one

☐ Hispanic / Latino
☐ Non-Hispanic / Latino
☐ Unreported / Refused to Report

Preferred Language

☐ English
☐ German
☐ Spanish

PRESENT HEALTH PROBLEMS:
Please list your complaints in order from the most severe to the least and estimate the amount of time you have had this complaint.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____
5. _____ How long? _____

Is condition related to an accident? ☐ No – **OR** – ☐ Auto ☐ Work related ☐ Other **Accident Date:** ___/___/___

How and when did it start? _____
What Doctors have you seen for this condition? _____
What makes it better? _____
What makes it worse? _____
Have you had surgery for this condition? ☐ Yes ☐ No If yes, when?_____
Do you have a family history related to this condition? _____

Female History: Date of last menstrual cycle _____/_____/_____ ☐ Regular ☐ Irregular
Are you pregnant at this time? ☐ Yes ☐ No

FOR OFFICE USE ONLY
Member of Doctor's Staff _____ Date: _____

INSURANCE INFORMATION:
Insurance Carrier: _____
Insured's Name: _____
Insured's Date of Birth: _____/_____/_____

Other Method of Payment: _____

I authorize payment of medical benefits to this office.

Signed: _____ Today's Date: _____
(Signature of patient or parent/legal guardian, if a minor)

1525 Bardstown Road ♦ Louisville, KY 40205 ♦ Phone: (502) 454-5000 ♦ Fax: (502) 454-5225

HIGHLAND CHIROPRACTIC

Dr. Charles E. Copeland, DC

HEALTHCARE AUTHORIZATION FORM

Patient's Name _____

Patient's SSN _____ Birth Date _____

SPECIFIC AUTHORIZATIONS

- I give permission to *Highland Chiropractic* to use my email address, physical address, phone number and clinical records to contact me with holiday cards and information about treatment alternatives or other health related information.

OPEN ROOM AUTHORIZATION

- I give *Highland Chiropractic* permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide an area for these conversations.

RIGHT TO REVOKE

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not retroactive to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to **Highland Chiropractic.** The written notice must contain the following information:

-Your name, SSN, and Date of Birth

-A clear statement of your intent to revoke this AUTHORIZATION

- The date of our request and your signature

The revocation is not in effect until received by Highland Chiropractic. This revocation does not affect any use of protected health information as allowed according to the Notices of Privacy Practices. In the event that you wish to modify or revoke any authorization granted in the Notice of Privacy Practices, a separate revocation must be delivered to Highland Chiropractic. You have the right to refuse to sign this AUTHORIZATION. In this event, Highland Chiropractic reserves the right to refuse to provide treatment.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST.

Print Patient's Name _____

Signature of Patient or Parent/Legal Guardian _____

Date _____

HIGHLAND CHIROPRACTIC
Dr. Charles E. Copeland, DC

ASSIGNMENT OF BENEFITS
I request that payment under my medical insurance program be made to North Shively Chiropractic, LLC dba Highland Chiropractic for any services or equipment furnished to me. I authorize North Shively Chiropractic, LLC dba Highland Chiropractic to release any information needed for this claim to the necessary carriers or their intermediates. I also request that a copy of this authorization be used in place of the original.

STATEMENT OF CONFIDENTIALITY
I authorize the release of necessary medical information to North Shively Chiropractic, LLC dba Highland Chiropractic for purposes of processing this or any related insurance claims. I also give North Shively Chiropractic, LLC dba Highland Chiropractic the authority to make available any requested documents contained in my file to myself and/or other health care providers involved in the treatment of my condition.

AGREEMENT
I acknowledge that I am fully responsible for the payment of any services or equipment provided to me by North Shively Chiropractic, LLC dba Highland Chiropractic. I understand that if North Shively Chiropractic, LLC dba Highland Chiropractic submits a claim for billed charges to my health plan(s) on my behalf, I am not relieved of my financial responsibility for payment. In the event that the health plan or any third party payor does not pay the entire billed amount, I agree to pay any remaining balance except as restricted by Highland Chiropractic's contractual reduction of fees or specific Medicare and Medicaid reimbursement policies.

By my signature below, I acknowledge and accept the terms and conditions stated above.

Patient Name: _____

Patient Signature: _____
(Or Signature of Parent/Legal Guardian)
Date: _____
_____
_____

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby designate Dr. Charles E. Copeland, DC and North Shively Chiropractic, LLC dba Highland Chiropractic (hereafter referred to as "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other healthcare expense(s) as the result of the services I received from my doctor.

Patient's Signature: _____
(Or Signature of Parent/Legal Guardian)
Patient's Printed Name: _____

Date: _____

HIGHLAND CHIROPRACTIC
Dr. Charles E. Copeland, DC

DISCLOSURE & CONSENT

CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

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 the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

To be completed by the patient:

_____Print name

_____Signature of patient/or Representative

_____Date signed

_____Member of doctor's staff

_____Date signed

HIGHLAND CHIROPRACTIC
Dr. Charles E. Copeland, DC

Medication and Medication Allergy List

Patient Name: _____ Date: _____

Please list your current medications with frequency (how often do you take?) and dosage:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any medication allergies that you have:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

HIGHLAND CHIROPRACTIC
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have been provided access to the Notice of Privacy Practices which provides a complete description of how my protected health information may be used and disclosed. I consent to access my copy of the Notice of Privacy Practices as available at www.HighlandChiropractic.com on the Online Forms page under the New Patient Center. I understand that if at any time I wish to receive a printed copy of the Notice of Privacy Practices it will be provided to me by Highland Chiropractic upon my request.

I understand that I have the following rights and privileges:

- The right to review that notice prior to signing this consent.
- The right to request restrictions as to how my protected health information and/or contact information may be used or disclosed.

_____ _____

Patient Signature (or Parent/Legal Guardian) Date