River Ridge Chiropractic and Natural Medicine

Patient Intake Form

Name_____

Date of Birth_____ Ht_____ Wt_____

Street/PO_____City_____St_____Zip_____

Cell Phone_____ Home Phone _____ Work Phone_____

TEXT Appointment Reminder - YES _____ **NO** _____ Cell Carrier _____

Home Email_____

Employer's Name_____ Position _____

Employer's Address _____

Emergency Contact_____ Phone_____

Relationship _____ Referred by_____

Reason for visit: _____

Date symptoms began_____ Have you been treated for this condition? _____

If **yes**, please describe _____

Are you taking any medications? _____ If yes, please list _____

Date of last physical_____ Name of current Physician_____

List any **recent** surgeries, illnesses, accidents, falls, etc. _____

_____

Person responsible for payment (if other than patient)_____

Insurance Company_____

*Policy Holder's Name_____*DOB_____

*Policy Holder's Address _____

*Relationship to Policy Holder_____ Policy Holder's Employer_____

Insurance Information

I understand and agree that health insurance policies are an agreement between an insurance carrier and me. Furthermore, I clearly understand that this chiropractic office will prepare my necessary reports, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent of Professional Services and Release of Information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case, and I further authorize him to disclose all or any part of the clinic's record to any person or corporation which is liable under a contract to the clinic or to the patient for all or part of the clinic's charge including but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare compensation carriers or the patient's employer.

Patient (or) Guardian Signature_____

Today's Date_____

*We MUST have subscriber's/policy holder's information to file your insurance. Thank you!

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

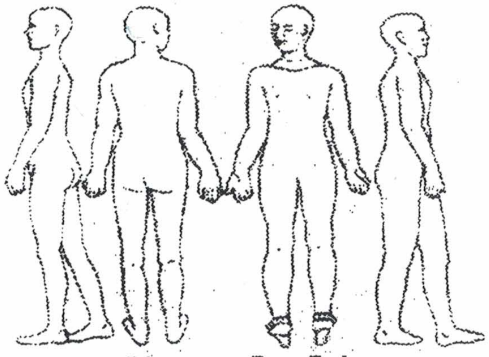
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ Yes ❑ No

SYMPTOM LOCALIZATION



P ____ Pain
N ____ Numb
S ____ Spasm

T ____ Tender
H ____ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor Appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Exercise
- ❑ Drug Abuse
- ❑ _____

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE .....

Patient accepted? ❑ Yes ❑ No Doctor's Signature _____

River Ridge Chiropractic and Acupuncture
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803

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.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you

when necessary. *Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

YOUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Print Name _____

Signature _____ Date _____

If you are a minor being represented by another party:

Print Name of representative _____

Signature of representative _____

Date _____

River Ridge Chiropractic and Natural Medicine
1201 Bleachery Blvd, Ste 203
Asheville, NC 28803
828-274-6602

MEDICAL RECORDS RELEASE FORM

RE: PATIENT: _____

Last 4 SS#: _____

DOB: _____

This is to authorize Dr. Bart Hodgins, DC to release any and all medical information or opinion which may be requested by another doctor regarding my physical condition and treatment rendered. This would include any x-rays or MRI reports which Dr. Hodgins may have regarding my condition or treatment.

_____

Patient Signature

_____

Date

River Ridge Chiropractic & Natural Medicine

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PATIENT AUTHORIZATION
For Appointment Reminders and Scheduling Related Matters

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues. The use of this information is intended to make your experience with our office more efficient and productive.

If you choose not to authorize the use of this information by our staff, your decision will have no adverse effect on your care from River Ridge Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name: _____

Signature: _____

Date: _____

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Patient Guide to River Ridge Chiropractic & Natural Medicine

1201 Bleachery Blvd, Ste 203
Asheville, NC. 28803

Thank you for choosing River Ridge Chiropractic & Natural Medicine to be your healthcare provider. We appreciate having the opportunity to be a part of your optimal health. The following summary of our financial policies is designed to answer questions and concerns you may have about our financial relationship. Please let us know if you have questions that aren't addressed in this notice.

Patient Appointment Hours:

Mon, Wed, Thurs: 7:45 am – 11:45 pm & 1:45 pm – 4:45 pm
Tues: 7:45 pm – 11 am
Closed Daily 12-1:30 for Lunch
If you are unable to keep your scheduled appointment, we request 24 hours notice, so that we may have that time available for another patient who may be needing treatment.

Contact Information:

Telephone: 828-274-6602
Fax: 828-274-6604
Email: riverridgechiropractic@gmail.com
Website: www.riverridgechiropractic.com

Payment Methods

All payment is expected at the time of service. We accept cash, personal checks, debit cards, Visa, Master Card, Discover, and American Express. There will be a $15 service fee for returned checks.

Insurance

We are in-network providers for most major health plans, and are happy to file claims on your behalf. In order for us to file your insurance claims, we will need to have all necessary information, including a copy of your current valid insurance card. Under the terms of our contract with the various health plans, payment of copays, deductibles, and/or co-insurance is due at each visit. As the patient or guardian, we recommend that you be familiar with the contract between you and your insurance carrier, and fully understand the benefits of your policy. We make every effort to obtain accurate information from each insurance company, however, we cannot guarantee that services or products will be covered until the claim has been processed and reimbursement made by the insurance company. Services not paid by an insurance company are the responsibility of the patient or account guarantor.

Auto Accidents/MVA's

We file liability and med-pay insurance claims for auto accidents claims. To expedite the filing and payment of your claims, we request a copy of the police report (if applicable), insurance information including claim numbers, mailing addresses, and phone numbers for all parties involved. Denied or unpaid personal injury claims are the responsibility of the patient.

Billing

If there is a balance on your account we will do our best to send you a timely billing statement, however it is your responsibility to make sure your account is paid in a timely manner. For accounts sent to an outside collections agency, there will be a 30% finance charge added to the balance due.

I have read and understand the terms of the above agreement.

Name: _____

Signature: _____

Date: _____

Assignment of Benefits

I hereby assign to Dr. Bart Hodgins and River Ridge Chiropractic all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment checks directly to River Ridge Chiropractic for all medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Print Patient Name:

_____

Patient/Responsible Party
Signature:

_____

Date: _____