Dudley Chiropractic and Acupuncture

301 S. Broad St. Mooresville, NC. 28115. ph 704-663-2010 fax 704-660-9292

DATE _____

About You

Name_____ Email Address_____

Cell#_____ Cell Carrier (ie. AT&T)_____ Home#_____

Birth Date_____ Gender ☐ F ☐ M Marital Status _____ Wt _____ Ht _____

Address_____ City_____ State_____ ZIP_____

How did you hear about our office? ☐ Doctor ☐ Friend ☐ Family Name:_____

☐ Google ☐ Yelp ☐ Other _____

About Your Insurance

I understand and agree that health and accident insurance policies are an arrangement between an ins. carrier and myself. I understand that Dudley Chiropractic will prepare any necessary reports and forms to assist me in collecting from the insurance company, and that any amount authorized to be paid directly to Dudley Chiropractic will be credited to my account upon receipt.

Insurance Co_____ ID#_____ Group # _____

Address_____ Phone#_____

Occupation_____ Employer_____ Work#_____

Insured Name_____ Employer_____ DOB_____ Relationship_____

Experience with Chiropractic

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No Dr.'s Name_____

If yes, reason for treatment:_____ Apprx Date of Last Visit_____

Health History

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No If yes, please explain:_____

Have you had any recent Automobile Accidents? ☐ Yes ☐ No If yes, please explain:_____

Have you had any sports injuries? ☐ Yes ☐ No If yes, please explain:_____

When was the last time you had a spinal x-ray?_____ What medications are you currently taking?_____

_____

What supplements you are currently taking (i.e., vitamins, herbs)?_____

How many glasses of water do you drink each day?_____ How do you sleep (i.e. back, side, stomach)?_____

Do you smoke?_____ How many per day?_____ Do you drink alcohol?_____ How many drinks per day?_____

Do you drink coffee?____How many cups per day?____ Do you exercise regularly?_____ How many times per week?_____

Are you aware of any poor postural habits?_____

Reason for This Visit

Describe the purpose of this visit:_____

When did this condition begin?_____ This condition has: ☐ Worsened ☐ Stayed Constant ☐ Comes and Goes

Does this condition interfere with your work, sleep, daily routine, or other activities? ☐ Yes ☐ No

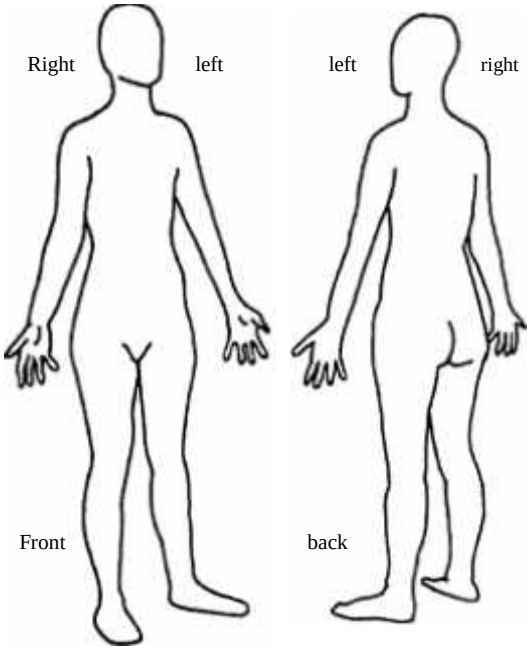
Please explain:_____

Has this condition occurred before? ☐ Yes ☐ No Please explain:_____

Where Do You Feel Pain?

Please circle all areas of pain or discomfort.

DOCTOR NOTES



What Kind of Pain?

/ stabbing

^ burning

* numbness

> pins & needles

X aching

Overall intensity of complaint: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

What aggravates the problem?_____

What relieves the problem?_____

Please list any other questions or concerns you would like addressed:_____

_____

Survey of Overall Health

Please check any health conditions you may be experiencing:

CERVICAL SPINE (NECK)

Do you experience:☐ Neck pain ☐ Pain into shoulders/arms/hands ☐ Numbness/tingling in arms/hands
☐ Headaches ☐ Hearing disturbances ☐ Weakness in grip
☐ Dizziness ☐ Visual disturbances ☐ Coldness in hands/feet
☐ Thyroid conditions ☐ Sinusitis ☐ Allergies/hay fever
☐ Recurrent colds/flu ☐ Jaw pain/clicking

THORACIC SPINE (UPPER BACK)

Do you experience:☐ Upper back pain ☐ Heart palpitations ☐ Heart murmurs
☐ Tachycardia ☐ Heart attacks/angina ☐ Recurrent lung infections
☐ Asthma/wheezing ☐ Shortness of breath ☐ Pain on deep inspir/expiration

THORACIC SPINE (MID BACK)

Do you experience:☐ Mid back pain ☐ Pain into your ribs/chest ☐ Indigestion
☐ Heartburn ☐ Nausea ☐ Ulcers/gastritis
☐ Tired/irritable after eating or when you haven't eaten for awhile ☐ Hypoglycemia

LUMBAR SPINE (LOWER BACK)

Do you experience:☐ Low back pain ☐ Pain into your hips/legs/feet ☐ Numbness in hips/legs/feet
☐ Sexual dysfunction ☐ Frequent/difficulty urinating ☐ Recurrent bladder infections
☐ Constipation/diarrhea ☐ Menstrual irregularities/cramping ☐ Hypoglycemia
☐ Weakness/injuries in your hips/knees/ankles ☐ Coldness in your legs/feet

Please list any health conditions not mentioned_____

Physician Info

Primary Physician Name_____

I give permission for Dudley Chiropractic to send a brief progress report to my Physician. ☐ PLEASE INITIAL

Who Should Receive Bills for Payment on Your Account?

☐ Self ☐ Parent ☐ Spouse ☐ Auto Insurance ☐ Personal Health Insurance

Payment Method (check one)

☐ Cash/Check ☐ Credit Card ☐ HSA

Fees For Typical Services

New Patient Exam $40-$125 Adjustment $40- $50 Acupuncture $30-$70 X-rays $45-$110 Class IV Laser Therapy $20

Spinal Decompression $25 (added to adj. charge) Intersegmental Traction $30 Myofascial Work (TA) $45 Elec Stim $30

PLEASE NOTE: This represents some of the common procedures performed and submitted to the insurance carriers, and are based on reasonable and customary fees established in the industry. According to state law, all services performed need to be billed for. Cash discounts may apply for non-insured.

Assignment of Benefits

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Dudley will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to Dr. Dudley for services rendered.

In the event that any insurance company, obligated by contractual agreement to make payment to me or to Dr. John Dudley for the charges made for your services, refuses to make payment upon demand by Dr. John Dudley, I hereby assign and transfer to Dudley Chiropractic, the cause of action that exists in my favor against any such company (the name(s) of which believed to be correctly set forth under pertinent data), and authorized you to prosecute said action in my name as you see fit and further authorize you to compromise, settle, or to otherwise resolve said claim as you see fit. I understand that I personally owe and agree to pay whatever amounts not collected from the insurance company proceeds, whether it is all or part of what is due, to John Dudley. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of North Carolina. This includes the reasonable costs of collecting, including attorney fees and count costs if incurred. Should any account become delinquent, the patient is responsible for all charges incurred. Amount is subject to monthly interest charge of 1.5% per month (18%annum) and any necessary collection procedures fees. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full. This Authorization for Assignment will be continual effect until revoked by both parties. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

_____ _____

Signature Date

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Disclosure & Consent to Chiropractic and/or Acupuncture Examination and Care

I understand that, in the practice of chiropractic and/or acupuncture, like in any heath care profession, there are some risks involved with examination and treatment. I have had the opportunity to discuss with Dr. Dudley, my diagnosis, the nature and purpose of chiropractic adjustments, acupuncture application if applicable, and other procedures and alternatives, as well as any concerns I have concerning any risks that may exist.

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, and if applicable, acupuncture treatment on me (or the patient named below, for who I am legally responsible) by Dr. John Dudley, D.C. 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 backup for Dr. Dudley.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Also, It is understood and agreed that payment to Dudley Chiropractic and Acupuncture for X-rays is for examination of X-rays only. The X-ray negative (digital form) will remain the property of this office. It is kept on file where it may be seen at any time while I am a patient at this office.

Consent for Use of Disclosure of Health Information (HIPPA Requirement)

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. There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

With your permission, we may disclose the use of pictures and written testimony within our practice to spread awareness and the benefits of chiropractic and/or acupuncture to others.

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.

_____ _____

Signature Date