Knight Family Chiropractic ▪ Chiropractic Case History/Patient Information

Date: _____

Name _____ Social Security # ☐☐☐ ☐☐ ☐☐☐☐

Home Phone _____ Cell Phone _____ Cell Carrier: _____

Address _____

City: _____ State: _____ Zip: _____

E-mail address: _____ Fax # _____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer: _____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer: _____

How many children?_____Names & Ages of Children: _____

_____

Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____ Last Physical: _____ Last Lab Work: _____

May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: _____

_____

Days lost from work:_____ Date of last physical examination:_____

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

How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to your major symptom?

Yes _____ No _____. If yes, describe _____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

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, describe _____

If no, what have you tried to do that has not helped? _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

WOMEN ONLY: Are you pregnant or any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain **LMP** _____

PAST MEDICAL HISTORY: Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones __Osteoarthritis __Eating Disorder __Ulcers
__Circulatory Problems __Epilepsy __Alcoholism __Coughing Blood
__Rheumatoid Arthritis __Pace Maker __Drug Addiction __High/Low Blood Pressure
__Seizures/Convulsions __Strokes __HIV Positive __Excessive Bleeding
__A Congenital Disease __Cancer __Gall Bladder __Ruptures
__Depression __ Diabetes __Tuberculosis __ Asthma
__Kidney Disease __Liver Disease __Mental Illness __Heart Disease
__Lung Disease

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or **surgeries**? Women, please include information about childbirth (include dates): _____

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

If yes, describe: _____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications, nutritional products or food? ☐ Yes ☐ No

If yes, describe: _____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week? _____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list: _____
Do you consume caffeine?____ If so, how much per day: _____
Do you exercise?_____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents: Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one) Mother: living___ deceased____ Current age if still living:_____
Cause of death and age at death if deceased:_____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

_____

FAMILY DISEASES: (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____ Cancer____ Mental Illness____
Diabetes ____ Asthma____ Heart Disease ____
Stroke ____ Kidney Disease____ Lung Disease____
Arthritis_____ Liver Disease ____ Other _____

Remarks: _____

_____

Patient's Signature:_____ Date: _____

Guardian's Signature Authorizing Care:_____ Date: _____

Knight Family Chiropractic
FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. For future visits, we will discuss payment options to make your chiropractic care affordable.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment.** As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and **you are personally responsible for payment of any non-covered services, deductibles or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/Personal Injury Protection portion of your auto insurance.
3. We will accept a Letter of Protection from an Approved attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred if they accept liability.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS
We are preferred providers for the most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After the deductible is satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS
Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

CREDIT CARD GUARANTEE/ELECTRONIC DEBIT
ALL patients with ALL types of cases (Patients without Insurance, Group or Individual Insurance, Personal Injury & Medicare) are required to have a Credit Card Guarantee and/or an Authorization for Electronic Debit on file.

FINANCING OPTIONS
Our clinic works hard to give you affordable care that has been recommended to you. We offer the following financing options: *Care Credit, HealthCare Payment Solutions/Cleargage.*

INSURANCE FORMS/PAYMENT
If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Knight Family Chiropractic. **I understand that my insurance is an arrangement between me and my insurance company, and NOT between Knight Family Chiropractic and my insurance company.** I request that Knight Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Knight Family Chiropractic that fees will be due and payable immediately.

_____ _____
Patient's signature (or guardian if patient is a minor) Date

_____
Witness

KNIGHT FAMILY CHIROPRACTIC
INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

TO THE PATIENT: PLEASE READ THIS ENTIRE DOCUMENT PRIOR TO SIGNING IT.
IT IS IMPORTANT THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT.
PLEASE ASK QUESTIONS BEFORE YOU SIGN IF THERE IS ANYTHING THAT IS UNCLEAR.

The Nature of the Chiropractic Adjustment

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure when I treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced with you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and therapy, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Vital signs
Range of motion testing	Orthopedic testing	Basic neurological testing
Muscle strength testing	Postural analysis testing	Hot/cold therapy
Radiographic studies	Other:	

The material risks inherent in a chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you feel you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

- Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants & pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Consent to treatment of minor

I hereby request and authorize Knight Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my: _____
(indicate relationship to child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Knight Family Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Date Patient's Printed Name

_____ _____
Patient's Signature Signature of Parent or Guardian (if a minor)

_____
Doctor's Signature

_____
Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

Patient:_____

Insured SS#/ID#_____

Claim/Group #:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Knight Family Chiropractic

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Ryan L. Knight, D.C.
Knight Family Chiropractic
3230 S. Eisenhower Parkway
Denison, Texas 75020

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ this _____ day of _____,_____

_____ _____
Insured Witness

Knight Family Chiropractic | HIPAA Medical Information Release Form

Patient Name: _____ Date of Birth: ____/____/____

Release of Information

CHECK ONE:

[ ] Information is not to be released to anyone.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

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

Messages

Please call [ ] my home [ ] my work [ ] my cell

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures established at Knight Family Chiropractic.

_____

Signature of Patient Date

_____

Witness Date

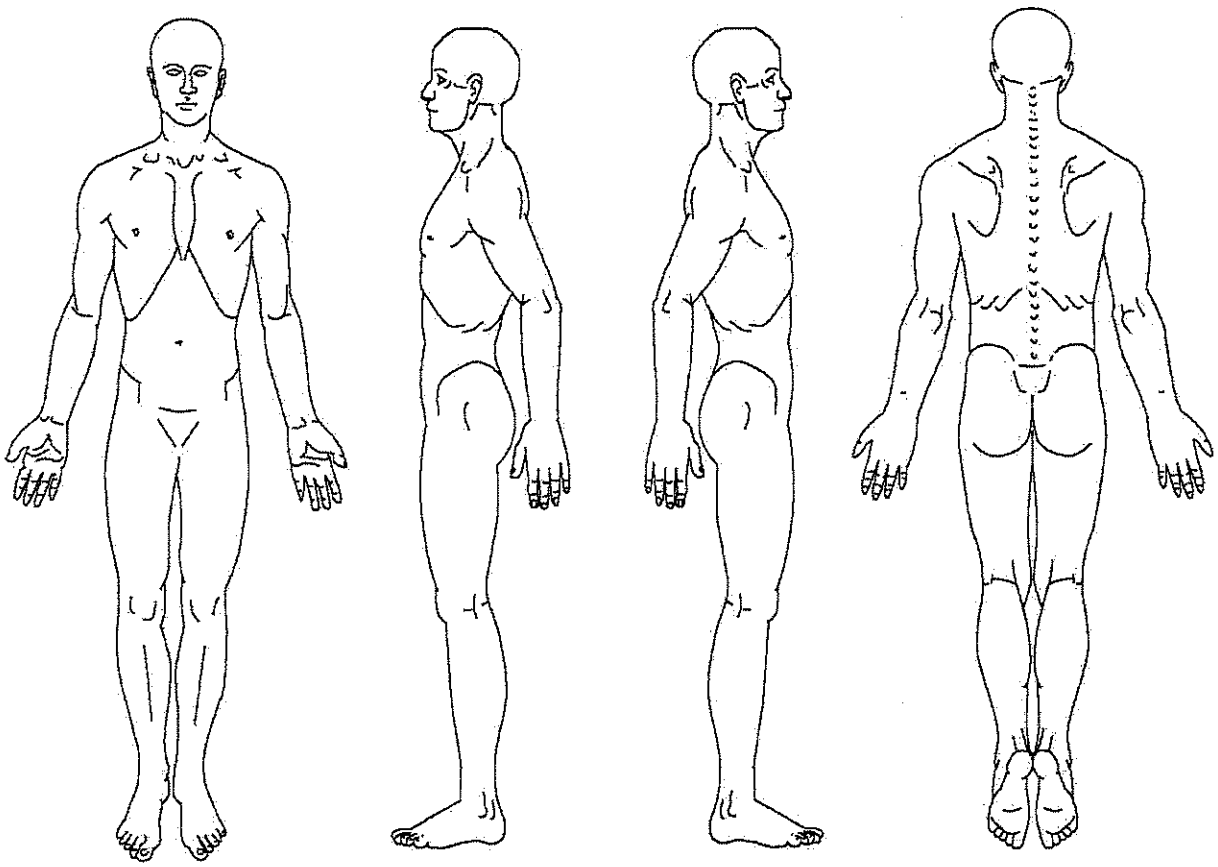
KNIGHT Family CHIROPRACTIC

PAIN DRAWING

Name_____ **Date**_____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
≈≈	═══	OOOO	.....	//////////	XXX



No Pain 1_____10 Worst Possible Pain

Please make a slash through this line to indicate the level of your pain.

Patient Signature

_____

KNIGHT *Family* CHIROPRACTIC

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner: _____

OTHER COMMENTS:

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

KNIGHT Family CHIROPRACTIC

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____

Examiner

OTHER COMMENTS:

_____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.