First Name _____ Middle Initial ____ Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ May we contact you by text and email?_____

Gender you were born as: □ Male □Female

Gender- How do you idendify? □Man □Non binary □Woman □Transgender
□Prefer self described as:_____□Prefer not to answer

Employment Status: □ Employed□ Unemployed □ FT Student □ PT Student □ Other__

Occupation:_____

Emergency Contact:

Contact Name _____ Relationship to Patient_____

Contact Home Phone (_____) _____-_____Cell Phone (____) _____-_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health insurance □ Spouse □ Worker's Comp □Auto Ins. □ Other _____

Insurance Company Name: _____

Ins. Card ID# _____ Group # _____

Personal injury/MVA Insurance Claim # _____

Adjuster Name and phone:_____

Primary Physician Name and Number: _____

May we communicate with your PCP regarding your care? Y/N

Date of last exam: _____

Name of most recent Chiropractor: _____ Date of last visit_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□Stroke
□ Other _____			

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□ Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□ Other _____			

Fractures: _____ Date of injury:_____
_____ Date of injury:_____
_____ Date of injury:_____

Social History: (Check all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Chew Tobacco:	□ occasional	□ often	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Wear Seat Belts:	□ occasional	□ always	□ never

Other _____

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper
□ Other _____			

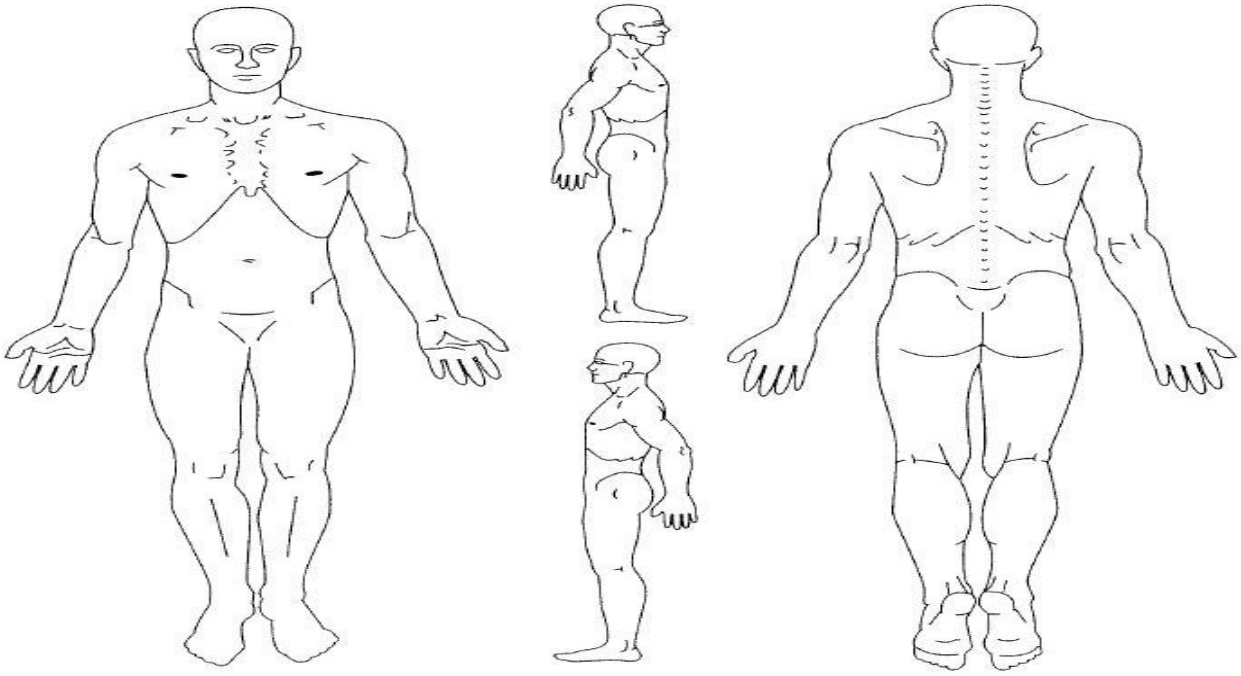
Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____Day_____Year_____

What are your goals for chiropractic care?_____

Previous interventions, treatments, surgeries or care you have sought for your complaint_____

_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly	□ Frequently	□ Occasionally	□ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

□Sharp □Dull Ache □Numb □Shooting □Burning □Tingling □Stabbing □ Other_____

How are your symptoms changing?

□Same □Not Changing □Getting Worse

Describe your secondary complaint:_____

When did your symptoms begin? Month_____Day_____Year _____

Did it begin □Gradual □Sudden □Progessive over time

How often do you experience these symptoms?

□ 25% □ 50% □ 75% □ 100%

Does the pain radiate into your:

□ Arm □ Leg □Does not radiate

Do you have numbness or tingling? Y/N

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no pain. 10 being extreme)_____

What makes your symptoms increase/worse (Activities)_____

_____

What makes your symptoms decrease/better?_____

_____

Have you had similar symptoms in the past? Y/N If so, when?_____

Are your symptoms worse at certain times of the day? Y/N If so, when?_____

Medications/supplements: _____

Exercise//Hobbies: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic X-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parent and Relationship to Patient: _____

Signature of Guardian/Parent: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

Oak City Chiropractic

Cancellation Policy

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a 24 hour cancellation policy with a $45 missed appointment fee.

If you cannot make your scheduled appointment, please call us at **919-213-0881** and cancel at least 24 hours prior to your appointment so that Dr. Fay may accommodate other patients. To cancel or make changes to Monday appointments please call over the weekend and leave a voice message.

We appreciate your timeliness should you need to rearrange or reschedule your appointments. Of course, we are courteous with emergencies.

I have read and understand this policy:

Patient Name (Print) _____

Patient Signature (or Parent/Legal Guardian) _____

Date _____

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible,coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

I have read and understand my Financial Responsibility:

Patient Name:(print) _____

Patient Signature: _____ Date: _____

HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You make revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative: _____

Printed Name: _____

Date: _____