**Hudson Chiropractic – Karyn Dornemann, DC**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  | **2 Sherman Potts Dr. St.203** | **Ghent, NY 12075** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | **p:518-828-2133 f:518-751-2294** | **hudsonchiro@yahoo.com** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Today’s Date:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **PATIENT INFORMATION** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Name:** (Last, First MI) |  |  |  |  |  |  | **Preferred Name**: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Address:** |  |  |  |  |  |  |  |  | **City:** |  |  |  |  |  |  | **State:** |  |  | **Zip:** |  |  |  |  |  |
|  | **Home:** |  | **Mobile:** | **Mobile Carrier:** |  |  |  |  |  |  | **Work:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Email:** |  |  |  |  |  |  |  |  |  |  |  | **Gender:** M / F | **Marital Status:** Married / Other / Single |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Social Security #**: |  |  |  |  |  |  |  | \_ |  |  | **Date of Birth:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Student Status:** Full Student / Part Student / Non-Student |  |  |  | **Employed** | **Employer:** |  |  |  |  |  |  |  |  |
|  | **\*Referred By:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Ethnicity**: Hispanic or Latino / Other |  |  |  | **Preferred Language:** |  |  |  |  |  |  |  |  |  |
|  | **Race:** Asian / African Am. / Am. Indian or Alaskan Native / |  |  |  | **Smoking Status**: Every Day / Some Days / Former / Never |  |  |  |
|  |  | Other / Native Hawaii or Pacific Island / White |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **EMERGENCY CONTACT INFORMATION** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Full Name:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Home:** |  |  |  | **Mobile:** |  |  |  | **Primary Care Physician:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship**: Child / Parent / Spouse / Other: |  | **Doctor’s Phone:** |  |
|  |  |  |  |  |
|  |  |  |  |  |  |

**FINANCIAL INFORMATION**



Insurance Medicare Self-Pay (Cash)

**PRIMARY INSURANCE**

**Name:**

**Relation to Insured:** Self / Spouse / Parent / Child / Other

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Other than Self:* |  |  |  |  |  |  |  |
| **Insured’s Name**: |  |  |  |  | **Gender:** M / F |  |
| **Address**: |  |  |  |  |  |  |  |  |
| **City:** |  |  | **State:** |  | **Zip:** |  |  |
| **Phone:** |  |  | **Date of Birth:** | \_ |
|  |  |  |  |  |  |  |  |  |  |  |  |

**Who is responsible for payment?** Self / Other -*(Relationship)*

*Other than Self:*

Personal Injury/Auto Other (please explain):



**Insurance ID:**

**Employer / Group:**

*For Office Use:*

Chiropractic Copay Amount:

High Deductible Policy?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Copay Amount:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name**: |  | **Phone:** |  |  |  |  |  |
| **Address:** | **City:** |  | **State:** | **Zip:** |
|  |  |  |  |  |  |  |  |  |  |

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Patient No:** Page **1** of **6**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  **PATIENT CASE HISTORY** |  |
| **HISTORY OF CURRENT CONDITION** |  |  | **Patient Name:**  |  |  |
|  | **Describe Major Complaint:** |  |  |  |  |  |  |  |
|  | **Began When?** | / |  | / | **Describe how this began:** |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Grade Intensity/Severity of Complaint:** | None / Mild / Moderate / Severe / Very Severe |  |  |  |  |  |  |
| **Quality of the complaint/pain**: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: |  |  |  |  |  |  |
| **How frequent is the complaint present?** Off & On / Constant |  |  |  |  |  |  |  |  |  |  |  |  |
| **Does this complaint radiate/shoot to any areas of your body? No / Yes** *(Describe)* |  |  |  |  |  |  |  |
| *Head -* Base of Skull / Forehead / Sides-Temple | R / L / Both | *Leg -* Hip / Thigh-Knee / Calf / Foot-Toes | R / L / Both |  |
| *Arm –* Across Shoulder / Elbow / Hand-Fingers | R / L / Both | *Other Area:* |  |  |  |  |  |  |  |
| **Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other: |  |  |  |
| **Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: |  |  |  |  |  |  |
| **Which daily activities are being affected by this condition?** *(Describe)* |  |  |  |  |  |  |  |  |  |  |  |  |
| **For this CURRENT condition, have you:** |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: |  | **Where?** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* **Had any previous Surgery or Interventions in this area?** *(Describe)*
* **Taken any Medications?** OTC / Prescriptions

|  |  |
| --- | --- |
|  **Had any diagnostic testing?** X-rays / MRI / CT / Other: | **When and Where?** |
| **Describe any Secondary Complaints:** |  |  |  |  |

**HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)***

***Medications:***

**Allergies to Medications: *NONE*** *(List)*

**Current Medications: *NONE***

*(Already have a list? We can make a copy.)*

***Past Health History:*** *(Please list any past…)*

**Surgeries – Date, Type, and Reason: *NONE***

**Major Injuries/Traumas: *NONE***

**Major Hospitalizations: *NONE***

***Family Health History:***

**List *relevant* major health problems of immediate relatives:**

**Deaths in immediate family:** *(Cause and at what Age?)*

***Social and Occupational History:***

**Level of Education Completed:**

High School / Some College / College Grad. / Post Grad. / Other

**Lifestyle:** *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

**Habits:**

Cigarettes – *(#/day)*

Alcohol – *(amount/day)*

Coffee/Tea – *(cups/day)*

Rec. Drugs *(List)*

**Patient No:** Page **2** of **6**

**REVIEW OF SYSTEMS**

**Are you *currently* experiencing any of these symptoms? *(Check all the apply)***

 **Many of the following conditions respond to Chiropractic treatment.**

**General:** *(constitutional)*

Recent Weight Change

Fever

Fatigue

*None in this Category*

**Musculoskeletal:**

Low Back Pain



Mid Back Pain Neck Pain Arm Problems Leg Problems Painful Joints



Stiff/Swollen Joints Sore/Weak Muscles or Joints Muscle Spasms/Cramps Broken Bones

Other:



*None in this Category*

**Neurological:**



Numbness or tingling sensations Loss of Feeling



Dizziness or light headed Frequent or Recurrent Headaches Convulsions or seizures

Tremors

Stroke



Have you ever had a head injury? Ever been in an auto accident? Other:



*None in this Category*

**Mind/Stress:**

Nervousness



Depression Sleep Problems



Memory Loss or Confusion Other:



*None in this Category*

**Genitourinary:**

Sexual Difficulty



Kidney Stones Burning/Painful Urination



Change in force/strain w Urination Frequent Urination

Blood in Urine



Incontinence or Bed Wetting Other:

*None in this Category*

**Comments:**

**Gastrointestinal:**

Loss of Appetite

Blood in Stool



Change in Bowel Movements Painful Bowel Movements Nausea or Vomiting Abdominal Pain



Frequent Diarrhea Constipation Other:



*None in this Category*

**Cardiovascular & Heart:**

Chest Pains



Rapid or Heartbeat changes Blood Pressure Problems Swelling of Hands, Ankles, or Feet Heart Problems

Other:



*None in this Category*

**Respiratory:**

Difficulty Breathing

Persistent Cough

Coughing Blood

Asthma or Wheezing

Lung Problems

Other:



*None in this Category*

**Eyes and Vision:**



Wear contacts/glasses Blurred or double vision Glaucoma



Eye disease or injury Other:



*None in this Category*

**Ears, Nose and Throat:**



Bleeding gums / mouth sores Bad Breath or bad taste Dental Problems



Swollen throat or voice change Swollen glands in neck Ringing in the ears



Ear - Ache/Ringing/Drainage Sinus / Allergy problems Nose Bleeds



Hearing Loss Other:

*None in this Category*

**Endocrine, Hematologic, and**

**Lymphatic:**



Thyroid problems Diabetes



Excessive Thirst or urination Cold Extremities



Heat or Cold intolerance Change in hat or glove size Dry skin



Glandular or hormone problem Swollen Glands

Anemia



Easily Bruise or Bleed Phlebitis Transfusion



Immune system disorder Other:



*None in this Category*

**Skin and Breasts:**



Rash or Itching Change in Skin Color Change in hair or nails Non-healing sores



Change of appearance of a mole Breast Pain



Breast Lump Breast Discharge Other:

*None in this Category*

**Women Only:**

**Are you pregnant?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Yes - *Due Date*** |  | **/** |  | **/** |  |  |
|  |  |  |  |  |  |  |
| **No - *Last Menstrual Period*** |  |  |  |
|  |  |  | **/** |  | **/** |  |
|  |  |  |  |  |  |  |  |



Infertility

Painful or Irregular periods

Vaginal Discharge

Other:

*None in this Category*

***Pregnancies with Outcome & Date:***

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient or Guardian Signature |  | Date |  |  |
| **Patient No:** |  |  |  |  | Page **3** of **6** |



 **Welcome to Hudson Chiropractic!**

**Appointment Reminders Preferences:**

* I would like to receive appointment reminders via automated email the day of my

 appointment. Preferred Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I would like to receive appointment reminders via automated text message the day of my appointment. Phone #:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Phone Service Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I would prefer not to receive any appointment reminders from this office.

**HIPAA Notice:**

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

**Patient’s Signature: (parent if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Informed Consent for Chiropractic Treatment:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, on me (or of said minor) by Hudson Chiropractic Physicians and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains.  **Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process.**

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish torely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient’s Signature: (parent if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient No:** Page **4** of **6**



**Financial Policy**

Dear Patient:

Thank you for choosing us as your chiropractic health care provider. The following is a description of our financial policy:

* Payment for services is due at the time services are rendered.

o We accept cash, checks, Visa, MasterCard, Discover, and American Express.

* 1. We reserve the right to collect before services are rendered.
* All charges are your responsibility whether the insurance company pays or not.
	1. Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility

to verify your insurance coverage.

o Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.

* 1. If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
* Unless you are insured by Medicare or an insurance group which our doctors are participating members, it is our policy to collect 100% payment at the time the services are rendered.
* If you are a member of an HMO or Managed Care Program that requires referrals for specialty services, you are responsible for contacting your Primary Care Physician (PCP) for a referral prior to your visit if one is required by your agreement with your insurance company.
* We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with our office if you encounter such problems, so that we may assist you in the management of your account. You may reach the office at (518) 828-2133.
* **Chiropractic “maintenance care” is a non-covered benefit under all commercial insurance plans and Medicare. If you are receiving care less than twice a month, this is considered “maintenance.” We will ask you to convert to self-pay at that time.**

Again, thank you for selecting us as your chiropractic health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s or Guarantor’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Patient No:** Page **5** of **6**



 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Reminders and Health Care Information Authorization**

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

***(Please place a line through any method that you REFUSE to be contacted by and initial.)***

I may be *contacted* by: phone at home or work, mobile phone, e-mail, or postcard.

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Messages* may be left: on answering machine/voicemail at home, work, and on mobile

phone. Or with *individuals answering my phone* at home, or at

work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Signature | Authorized Provider Representative |
|  |  |  |
| Personal Representative Printed | Personal Representative Signature |

Description of personal representative’s authority to act for the patient.

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