Keegan Chiropractic Sports & Wellness Clinic

Patient Registration Form

Personal Information Today's Date______________

Name			Email	SS#	
Address			City	State	Zip
Home phone		Cell phone		Work phone	
Sex M F	Date of birth		Age	Marital status	
Spouse's Name			Children's Names & Age		
Employer			Your Occupation	Student? __Full time __Part	
Work Address			School Name		
In case of emergency call:				Phone #	
Primary care physician				Phone #	

Who may we thank for referring you to our office? ____________________________

Insurance Plan and Responsible Party Information

Insurance Company Name		Address		
City	State	Zip	Phone	
Policy #	Group #		ID#	
Policy Holder's Name		Address		
City	State	Zip	Phone	
Policy Holder's Date of Birth		SS#		Gender M F
Relationship to Patient ___Self ___Spouse ___Parent ___Guardian ___Other				
Policy Holder's Employer's Name		Address		
City	State	Zip	Phone	

Authorizations

It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The patient and the guarantor are responsible for all deductibles and copays at the time of the visit and any other fees in accordance with insurance contracts. The patient and guarantor are responsible for all elective or non-covered services and any service not considered medically necessary.

Financially responsible person if patient is a student or unemployed__________________Phone_____________

I authorize the release of my medical information necessary to process this claim and I request that payment of medical benefits be made directly to Keegan Chiropractic Sports & wellness Clinic. I hereby acknowledge that I am fully responsible for payment as listed above.

Signed ____Date______________Time________________

Please complete the information on the reverse side of this form also. Thank you!

What is the reason for your visit ?			
How did this condition develop?			When did it start?
Have you ever had this or a similar problem before? Y N			
Have you ever received treatment for this condition? Y N If yes when and what were the results?			
Has your problem been getting better, worse or staying the same?			
Is there anything that worsens your condition?			
How has this condition affected your life?	Rest and sleep?		Home life?
Work?	Recreation?		
Have you had any previous injuries, accidents or falls that may have contributed to this condition?			
Any Medical Diagnosis of your condition?			
Are you taking any medications?			
Any automobile accidents?	Describe your injuries:		
Any Allergies to medication?	Female: are you pregnant? Y N Date of LMP		
Please give your history of all major illness and surgery. Include date and area of the body.			
Please give your history of all X-rays or other diagnostic imaging studies other than dental taken:			
Do you eat balanced meals?	Take vitamins?	What type?	
Do you have a regular exercise program? (type and frequency)			
Are you training for any specific events?			Any training impediments?
Do you smoke?	Amount?	Do you drink alcohol?	Amount?
Are you currently using any Back or arch supports, heel lifts, orthotics or braces of any kind?			

Review of Systems

Please provide the following information about your general health and health history.
Circle P for personal history or F for family history.

P F	Alcohol/ Drug use	P F	Epilepsy	P F	Nervous system	Details
P F	Allergies	P F	Hysterectomy	P F	Nervous, anxiety, depression	
P F	Asthma	P F	Gallbladder	P F	Migraines/Headaches	
P F	Arthritis, gout	P F	Heart Problem	P F	Muscle/tendon disorder	
P F	Eating disorder	P F	Hepatitis	P F	Prosthetic implants	
P F	Bone/ joint condition	P F	Hernia	P F	Reconstructive surgery	
P F	Back/neck injury	P F	Hypertension	P F	Skin disorder/ cancer	
P F	Birth defect	P F	Thyroid/pituitary disorde	P F	Steroid use: prednisone	
P F	Blood disease	P F	HIV/AIDS	P F	Stroke	
P F	Blood vessel disorder	P F	Immune disorder Lupus	P F	Tumor, cyst, polyp, growth	
P F	Breast disease	P F	Stomach/ colon disorde	P F	Ulcers	
P F	Breast implants	P F	Intestinal disorder	P F	Weight problem	
P F	Broken bones	P F	Kidney/ Urinary	P F	Other, explain	
P F	Cancer	P F	Lung condition			
P F	Ear/nose/throat disease	P F	Male organ condition			

Circle your health goal(s) with Chiropractic treatment: Relief of pain, Resolution of condition, Improved lifestyle, Improved athletic performance, Less stress, Other ___________________________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.