Jubilee Family Chiropractic
12844 US Hwy 431, Guntersville, AL 35976
Phone: (256) 486-3911 Fax: (256) 486-3413

# PATIENT INFORMATION

**Patient Legal Name:** _____ **Prefers to be called:** _____ **Today's Date:** ___/___/___

**Social Security Number** _____ **Driver's License #** _____ **Birth Date:** ___/___/___ **Age:** ____ **Gender: F M**

**How did you learn about us?** _____ **If you were referred, by whom?** _____

**Military Status:** Are you currently serving, or have you previously served, in the military? **Y N**

*If you are under 18 years of age, who are your legal parents or guardian?*

*Parent/Legal Guardian:* _____ *Relationship:* _____ *Phone (_____)* _____

*Social Security Number:* _____ *Driver's License #* _____ *Date of Birth:* _____

*Who do you normally live with?* ☐ *Mother and Father* ☐ *Father* ☐ *Mother* ☐ *Legal Guardian* ☐ *None of these*

**Marital Status:** ☐ **Married** ☐ **Separated** ☐ **Widowed** ☐ **Single** **How many children?** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Phone number where we can leave a message: (_____)** _____ **Email** _____

Your Occupation _____ Employer _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____ Phone (_____) _____

**FAMILY HEALTH HISTORY**

1. Have any immediate family members been diagnosed with a life-threatening illness? _____
2. At what age did they receive that diagnosis? _____
3. Are/were any family members diabetics? _____
4. Is there a history of heart disease in the family? _____

**HEALTH CONCERNS - Please list your top health concerns/complaints that you would like to address (in order of priority)**

**1)** _____

**2)** _____

**3)** _____

**For health concern #1**, how would you rate your overall physical pain? 0 1 2 3 4 5 6 7 8 9 10 (worst)

What type of pain are you experiencing? _____

What caused your pain, condition or ilness?_____

What makes your condition better?_____

What makes your condition worse?_____

When did the condition begin, or when did you first notice it? _____

Have you ever had the same or similar condition Y N If yes, when? _____

Have you missed work or school due to your condition? Y N

Is this concern affecting your quality of life? Circle those applicable to you:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Work/School | Y N | Recreation | Y N | Sleep | Y N | Exercise/Sports | Y N |
| Walking | Y N | Sitting | Y N | Eating | Y N | Intimate/Personal Life | Y N |

Other: _____

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**For health concern #2**, how would you rate your overall physical pain? 0 1 2 3 4 5 6 7 8 9 10 (worst)

What type of pain are you experiencing? _____

What caused your pain, condition or illiness?_____

What makes your condition better?_____

What makes your condition worse?_____

When did the condition begin, or when did you first notice it? _____

Have you ever had the same or similar condition Y N If yes,when? _____

Is this concern affecting your quality of life? Circle those applicable to you:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Work/School | Y N | Recreation | Y N | Sleep | Y N | Exercise/Sports | Y N |
| Walking | Y N | Sitting | Y N | Eating | Y N | Intimate/Personal Life | Y N |

Other: _____

**For health concern #3**, how would you rate your overall physical pain? 0 1 2 3 4 5 6 7 8 9 10 (worst)

What type of pain are you experiencing? _____

What caused your pain, condition or illiness?_____

What makes your condition better?_____

What makes your condition worse?_____

When did the condition begin, or when did you first notice it? _____

Have you ever had the same or similar condition Y N If yes,when? _____

Is this concern affecting your quality of life? Circle those applicable to you:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Work/School | Y N | Recreation | Y N | Sleep | Y N | Exercise/Sports | Y N |
| Walking | Y N | Sitting | Y N | Eating | Y N | Intimate/Personal Life | Y N |

Other: _____

**HEALTH CARE PRACTITIONER HISTORY**

Have you ever received Chiropractic Care? Y N When: _____ Date of last visit: _____

Where: _____ Doctor(s) name(s): _____

How long under care? _____ Why did you stop? _____

Was there a particular health concern for you which you consulted the chiropractor?

_____

Did you find treatments helpful? _____

**Are you currently suffering from:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Headache | ☐ Dizziness | ☐ Light Bothers Eyes | ☐ Diarrhea | ☐ Head seems too heavy | ☐ Neck Pain |
| ☐ Loss of Memory | ☐ Clumsiness | ☐ Feet Cold | ☐ Neck Stiff | ☐ Tingling in arms/hands | ☐ Ears Ring |
| ☐ Hands Cold | ☐ Sleeping Problems | ☐ Tingling in legs/feet | ☐ Face Flushed | ☐ Nausea | ☐ Back Pain |
| ☐ Cold Sweats | ☐ Tension | ☐ Shortness of Breath | ☐ Fainting | ☐ Fever | ☐ Fatigue |
| ☐ Irritability | ☐ Loss of Smell | ☐ Chest pain/rib pain | ☐ Pain in arms/hands | ☐ Pain in legs/feet | ☐ Jaw Pain |

☐ Numbness in Arms/Hands ☐ Buzzing in Ears ☐ Constipation ☐ Nervousness ☐ Numbness in Hands/Feet

☐ Loss of Balance ☐ Loss of Strength in Arms ☐ Burning Muscle Pain ☐ Loss of Strength – legs ☐ Difficulty Swallowing

☐ Sharp/shooting pain ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Tired after full night's sleep

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**Have you experienced changes to:**

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐Respiratory (Breathing) ☐ Mouth (taste)

☐ Bladder ☐Bowels ☐ Sleep ☐ Emotion ☐ Appetite

Please explain: _____

**Have you been diagnosed with any of the following:**

☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems

☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Seizure Disorder

☐ Blood sugar/Insulin Abnormalities ☐ Cholesterol/Blood Lipid Abnormalities ☐ Low Blood Pressure

☐ Heart Attack ☐ Varicose Veins ☐ Hemophilia ☐ Pacemaker

☐ Asthma ☐ Sinusitis ☐ Arthritis ☐ Osteoporosis

☐ Tendonitis ☐ TMJ - Jaw Pain ☐ Gynecological Problems ☐ Cancer

☐ Fibromyalgia ☐ Depression ☐ Diabetes ☐ Digestive Conditions

☐ Chronic Fatigue Syndrome ☐ Anxiety ☐ Psychiatric Disorder ☐ Other _____

**HABITS**

Do you drink alcohol? Y N Drinks/Week: _____ Do you smoke? Y N Packs/Day: _____

Exercise: ☐ 5-7x/wk ☐ 3-5x/wk ☐ 1-3x/wk ☐ None

RESTFUL Sleep: ☐ 8+hrs ☐ 7-8 hrs ☐ 6-7 hrs ☐ 5-6 hrs ☐ <5 hrs

Work Activity: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐ Driving

Stress Level: ☐ Very High ☐ High ☐ Medium ☐ Low

Are you currently using medications to treat pain, inflammation or headaches? Y N

On average, over the past 30 days, how would you rate your overall daily physical pain? 0 1 2 3 4 5 6 7 8 9 10

On average, over the past 30 days, how would you rate your overall functional abilities (mobility, balance, strength): LOW AVERAGE HIGH

**NUTRITIONAL INFORMATION**

Lightheaded/irritable when hungry? Y N Crave salt/sugar? Y N Fatigue after meals? Y N

Need coffee/sweets 3-5pm? Y N Do you eat breakfast? Y N Do you eat snacks? Y N

What are your nutritional goals? _____

On average, over the past 90 days, how many servings of fresh vegetables have you consumed per day? 0 1 2 3 4 5+

On average, over the past 90 days, how many servings of fresh fruits have you consumed per day? 0 1 2 3 4 5+

Do you have any dietary restrictions? Y N If yes, please explain below: (vegetarian, gluten, Kosher, etc.)

_____

Are you currently taking any supplements? (List all below and where you purchased – Walmart, GNC, etc.)

_____

Do you get the recommended daily intake of 1000 IUs of Vitamin D3 per day? Y N

Do you get the recommended daily intake of 450mg of EPA & 300mg of DHA per day? Y N

Are you interested in nutritional information? Y N

Are you currently taking any medications (including over the counter medications)? (List all below with dosages)

_____

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**EMOTIONAL STRESS INFORMATION**

On average, over the past 30 days, how would you rate your overall level of psychological/emotional stress? LOW MEDIUM HIGH

**SURGERIES**

What surgeries have you had in the past?_____

**MASSAGE THERAPY HISTORY**

Have you had a professional massage before? Y N Date of last treatment: _____

Where: _____ Therapist(s)) name(s): _____

How long have you been under consistent therapy? _____ Why did you stop? _____

Was there a particular health concern for you which you consulted a massage therapist?

_____

Did you find massage therapy helpful?

_____

# MASSAGE THERAPY DISCLAIMER

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments will not be covered by insurance and I understand that it is my responsibility to pay for professional services when rendered.

It is our policy that payment be made at the time of each visit unless alternate payment arrangements are made.

**Missed Appointment & Late Arrivals**

We ask for patients to arrive at least 10 minutes before their scheduled appointment time, especially if paperwork still needs to be completed. Up to 15 minutes will be taken out of the scheduled message if late. After 15 minutes, we will need to reschedule the appointment and will charge half the amount of the service expected to be rendered.

**We require at least 48 hours notice of a cancellation or change in appointment.**

For missed appointments, or appointments canceled past the 48-hour notice, there will be a fee of half the amount of the service expected to be rendered at the appointment.
Having said this, we understand that emergencies sometimes occur. If there is a legitimate emergency that prevents you from keeping your appointment, please let us know and we will gladly waive this fee.

Patient Signature: _____ Date: ____/____/_____

*(If patient is a minor, consent must be signed by parent or official guardian)*

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/____

Rev. May 2023

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# OFFICE FINANCIAL POLICY

**WHEN INSURANCE IS NOT PRESENT:** It is customary to pay for professional services when rendered. It is our policy that payment be made at the time of each visit unless alternate payment arrangements are made.

**WHEN INSURANCE IS PRESENT:** **Verification of benefits does not guarantee third party payments!** If you have insurance, we will gladly file your insurance claim for you. We cannot guarantee third party insurance payment, however we will do our best to give you an estimate of what your insurance may cover. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

**GENERAL POLICIES:** A $35 fee for any returned checks will be charged to the patient's account. Full balance including returned check fee will be due immediately. All patients are on a cash basis until their respective insurance coverage and deductible may be verified. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If the patient is referred to another specialist or discontinues care for any reason, the bill is due and payable in full immediately, regardless of any claims submitted. If a balance remains on the patient's account for more than 90 days, it will be turned over to a collections agency. If after all claims have been completed, we will contact you if a balance or credit remains on your account. Please allow 3-8 weeks for full processing of all claims. We require a minimum monthly payment of $20 to avoid collections proceedings. Once three statements have been mailed and no payment has been received, your account will be turned over to a collections agency. By signing below, you acknowledge that your account will also be assessed an additional $20 fee for the cost of collections.

*By signing below, it states that you have read and understand the Office Financial Policy and agree to abide by these terms.*

***We charge $20.00 for any late cancellations and $40 for NO CALL/NO SHOWS.***
***We ask all patients to give notice before our doors open at 9am.***
***Otherwise, the fee will be charged to the credit card on file.***

Patient Signature: _____ Date: ____/____/_____

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# INFORMED CONSENT

*We want you to be informed about the care in which you may receive, including risks and benefits. This information is given so that you may be knowledgeable about your choice to consent to chiropractic care.*

Risks & Benefits of Care:

I understand and am informed that in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. In the majority of cases chiropractic care offers multiple benefits including the relief of neck pain, headaches and low back pain.

Alternative Treatments including risks and benefits:

Alternative treatments include, but may not be limited to, massage therapy, physical therapy, medication, or surgery. The risks involved with these alternative treatments should be discussed with practitioners within the relative field. Chiropractic care offers a non-invasive, natural treatment of vertebral misalignments.

Risks of no treatment at all:

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

***I understand and have read (or had read to me) the risks listed above. I acknowledge that the doctor was open with me about the risks of chiropractic and was willing to answer any questions that I have (or may have in the future). I intend for 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 Signature: _____ Date: ____/____/_____

(If patient is a minor, consent must be signed by parent or official guardian)

Parent Guardian or Legal Representative (Print Name): _____

Parent Guardian or Legal Representative Signature: _____ Date: ____/____/_____

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# Jubilee Family Chiropractic – Notice of Privacy Practices

***This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.***

**Introduction**

Jubilee Family Chiropractic is committed to giving you quality care and protecting your private health information (PHI). We are also committed to treating and using PHI about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information
This notice is effective 12/01/2021.

**Understanding your Health Information**

Each time you visit our office, a record of your visit is made. Typically, this record contains symptoms, examination and test results, diagnosis, treatment, and a plan for future care. This information serves as a:

Basis for planning your treatment,
Means of communication among the many health professionals who contribute to your care, Legal document describing care you received,
Means by which you or a third party payer can verify that services billed were provided,
A tool in educating health professionals, A source of data for medical research,
A source of information for public health officials charged with improving the health of this state and Nation,
A source of data for our planning and marketing,
A tool with which we can assess and continually work to improve the care we render and the outcome we achieve.

Understanding what is in your record and how PHI is used helps you to ensure its accuracy, better understand who, what when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosures to others.

**Your health information rights**

Although your health record is the physical property of Jubilee Family Chiropractic, the information belongs to you. You have the right to:

Obtain a paper copy of this notice of information practices upon request, Inspect and copy your health record as provided for by federal law (a reasonable fee may be charged to cover the cost of copying), Amend your health record as provided by federal law, Obtain an accounting of disclosures of your PHI as provided by federal law, Request communication of your PHI by alternative means or at alternative locations, Request a restriction on certain uses and disclosures of your PHI as provided for by federal law, and Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

**Our responsibilities**

To maintain the privacy of your PHI
To provide you with this notice as to our legal duties and privacy practices with respect to information e collect and maintain about you,
To abide by the terms of this notice, and
To accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
We reserve the right to change our practices and to make new provisions effective for all PHI we maintain. Should our information practices change, we will mail revised notice to the address you have supplied. Your responsibility is to notify us of address and insurance changes.
We will not use or disclose your PHI without your authorization, except as described in this notice. We will also discontinue to use or disclose your PHI after we have received a written revocation of the authorization according to the procedures included in the authorization.

**Examples of Disclosures for Treatment, Payment, and Health Operations:**

Treatment: We may use your PHI within our office to provide health care services to you or we may disclose your PHI to another provider if it is necessary to refer you to them for services.

Payment: We may disclose your PHI to a third party such as an insurance carrier, an HMO, a PPO, or in order to obtain payment for services provided to you.

Personal Injury: We may disclose your PHI to your attorney in order to obtain payment for services provided to you.

Operations: We may use your PHI to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Business Associates: There are some services provided in our organization through contacts with associates. Examples include physician services in the emergency department, radiology, and certain lab tests, referrals to other physicians, and other who may provide work in our office. We may need to disclose your PHI to our business associates so they may perform the job we have asked of them. We have an agreement with these associates to protect your PHI as well.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other established programs by law.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with law relating to workers' compensation or other programs. Your provider is required by law to report communicable diseases and certain conditions to the Center for Disease Control in Atlanta, GA. Your PHI will be protected by our office and the CDC or health center.

**For more information or to report a problem**

You may file a complaint with our practice's Privacy Officer, Jubal Matthews at 256-486-3911, or with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

Office for Civil Rights

U.S. Dept. of Health & Human Services

200 Independence Ave. SW

Room 509 F, HHH Building

Washington, DC 20201

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# Additional Information

**Please check all that apply:**

___ **The patient has x-rays, MRIs or other records they would like to be released to Jubilee Family Chiropractic.**
*(Please complete an Authorization to Release Records Form)*

___ **The patient has retained an attorney and is currently in litigation for an auto accident.**
*(Please complete Attorney Information & Auto Accident Questionnaire Form)*

___ **The patient will need a doctor's excuse for ___ work ___ school.**
___ Once ___ Every Visit ___ Only Upon Request From Patient
*(You will receive a doctor's excuse at the time of check-out)*

- I acknowledge that I may request a copy of Jubilee Family Chiropractic's Notice of Privacy Practices Policy. I consent to the use and disclosure of my protected health information as specified in Jubilee Family Chiropractic's Notice of Privacy Practices Policy.
- I understand that in the event I miss an appointment I give consent to Jubilee Family Chiropractic to send me a postcard regarding that appointment. I understand that I can request in writing an alternate form of communication.
- I understand that my records (including x-rays) are the property of Jubilee Family Chiropractic and if at any time I request a copy of my records there will be an additional charge for copying them (including x-rays).
- By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my heath care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my health care provider to disclose to third-parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

**Patient Signature:** _____ **Date:** ____/____/_____