Harris Sports & Family Chiropractic

CHIROPRACTIC - An Investment in Health - Our Greatest Asset

Dr. Theresa L. Harris

REQUIRED FOR YOUR CASE HISTORY FILE: ALL INFORMATION IS CONFIDENTIAL

Full Legal Name_____ Date of Birth_____ Age_____

Mailing Address_____

City_____ State_____ Zip Code_____

Telephone (Home)_____ Work_____ Cell_____

Receive text messages for appointment reminders? ☐ Yes ☐ No Email _____

Employer_____ Job Title_____

Address_____ City_____ State_____ Zip Code_____

Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name_____ Telephone_____

Spouse's Address_____ Employer_____

Emergency Contact_____ Relation_____ Telephone_____

Referred By _____

Past Chiropractic care? ☐ Yes ☐ No If yes, who/where?_____

Primary Care Physician _____ Telephone _____

Last Physical Examination _____ Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No If yes, explain:_____

What medication(s) are you currently taking? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, list:_____

Previous serious illness/hospitalization (please list and describe): _____

Have you ever had: Surgery ☐ Yes ☐ No Fractures ☐ Yes ☐ No Falls ☐ Yes ☐ No On-Job injury ☐ Yes ☐ No
If yes, describe: _____

Family History of: Heart Disease ☐ Yes ☐ No Cancer ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Arthritis ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No Other_____

If you are female, are you possibly pregnant? ☐ Yes ☐ No Date of last menstrual period _____

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Major Symptom/ Problem for this visit _____

Date symptoms first began_____

How did your symptom(s) first begin?_____

Pain is: ☐ Constant ☐ Come and go Is your condition getting: ☐ Worse ☐ Better ☐ Same

What activities aggravate your condition?_____

What activities lessen your symptom(s)_____

Is your condition worse during certain times of the day?_____

Is this condition interfering with: Work ☐ Yes ☐ No Sleep ☐ Yes ☐ No Daily Routine ☐ Yes ☐ No

Have you missed any work? ☐ Yes ☐ No How much?_____

Other Doctors seen for this condition_____

List home remedies tried_____

Check if you have had any of the following symptoms in the last 30 days:

☐ Pain worse at night ☐ Constant pain unrelated to motion ☐ Unexplained weight loss

☐ Loss of bowel or bladder control ☐ Bacterial Infection ☐ Surgery ☐ Fever or Chills

Check if you have ever had any of the following:

☐ History of Cancer ☐ History of HIV ☐ Use of Steroids ☐ Use of IV drugs ☐ Blood Transfusions

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.

AGREEMENT FOR PATIENTS WITH INSURANCE: *I will pay all co-payments or un-met deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from my insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information pertinent to my case to the insurance company.*

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, 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 to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available to 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.

Signature_____ Date_____

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Use the letter **C** if you have the condition Currently, or the letter **P** if you have previously had the condition.

_____Headaches
_____Neck Pain or Stiffness
_____Mid Back Pain or Stiffness
_____Low Back Pain or Stiffness
_____Arm Pain *R or L*
_____Shoulder Pain *R or L*
_____Arm Weakness *R or L*
_____Shoulder Weakness *R or L*
_____Pins & Needles in Arms *R or L*
_____Numbness in Fingers *R or L*
_____Knee Pain *R or L*
_____Leg Pain *R or L*
_____Foot Pain *R or L*
_____Pins & Needles in Legs *R or L*
_____Leg Cramps *R or L*
_____Leg Swelling *R or L*
_____Numbness in Toes *R or L*
_____Cold Feet *R or L*
_____Cold Hands *R or L*
_____Dizziness or Light Headed
_____Loss of Balance or Coordination

_____Depression
_____Sleeping Problems
_____Fatigue
_____Weakness
_____Buzzing or Ringing in Ears
_____Pain or Trouble Breathing
_____Chest Pain
_____Digestive or Eating Problems
_____Stomach Upset/Pain
_____Blood in Urine or Stool
_____Constipation or Diarrhea
_____Difficulty/Pain with Urination
_____Fainting or Convulsions
_____Nausea
_____Vomiting
_____Seizures
_____Heart Trouble
_____Stroke
_____Asthma
_____Emphysema

_____Sinus Trouble
_____Tension or Irritability
_____Nervousness Allergies
_____Rheumatic Fever
_____Loss of Smell
_____Loss of Taste
_____Kidney Trouble
_____Diabetes
_____Tuberculosis
_____Immunosuppression
_____Anemia
_____Loss of Memory
_____Sexual Dysfunction
_____Osteoporosis
_____Pneumonia
_____Thyroid Problems
_____High Blood Pressure
_____Breast Problems
_____Rashes
_____Loss of Energy
_____Abnormal Menstruation

IF YOU WERE INVOLVED IN AN AUTOMOBILE ACCIDENT (IF CASE IS STILL OPEN), PLEASE ANSWER THE FOLLOWING:

Is this your first automobile accident? ☐Yes ☐No If not, date(s) of other accident(s):_____

Did you go to the Emergency Room? ☐Yes ☐No *Where?*_____
By Ambulance? ☐Yes ☐No

Date of Accident_____ Driver of Car _____
Year/Model of Car_____ Damage to Vehicle $_____

TYPE OF ACCIDENT: ☐Front End Impact ☐Rear End Impact ☐Driver Side ☐Passenger Side

WHERE WERE YOU SEATED IN THE CAR: ☐Front Seat ☐Back Seat ☐Driver Side ☐Passenger Side

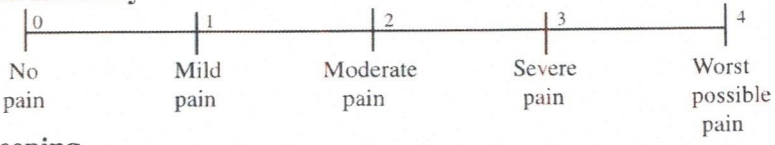
HEAD/BODY POSITION AT THE TIME OF IMPACT: ☐Head turned left/right ☐Head looking back
☐Head straight forward ☐Body Straight in seated position ☐Body rotated left/right
☐Body leaning on console or door

Did you see the accident coming? ☐Yes ☐No Did you brace for the impact? ☐Yes ☐No
Seatbelt worn? ☐Yes ☐No Were you bruised or cut? ☐Yes ☐No

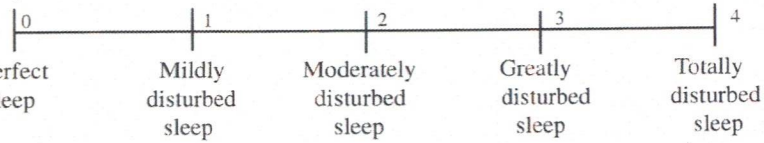
Functional Rating Index

For each item below, **please circle the number which most closely describes your condition right now.**

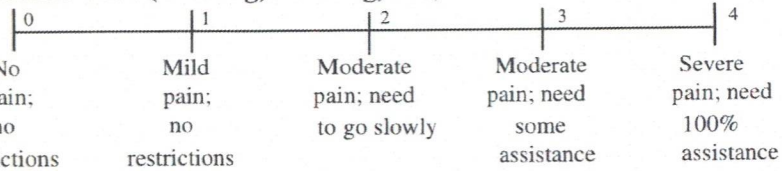
1. Pain Intensity



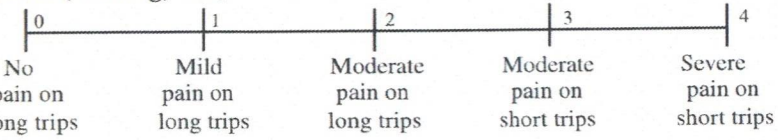
2. Sleeping



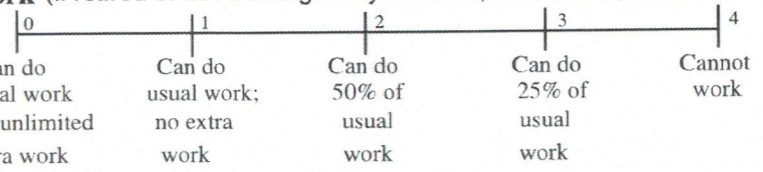
3. Personal Care (washing, dressing, etc.)



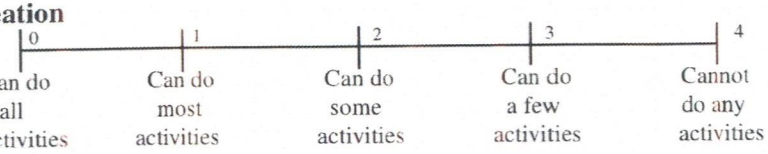
4. Travel (driving, etc.)



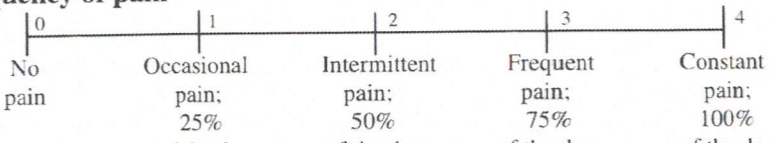
5. Work (if retired or not working: daily activites, housework, errands, etc.



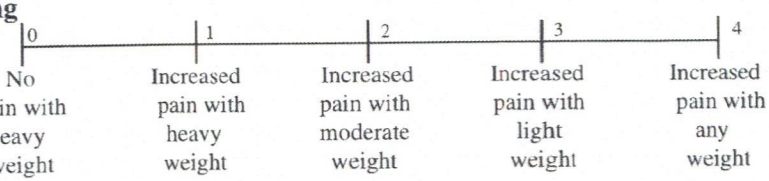
6. Recreation



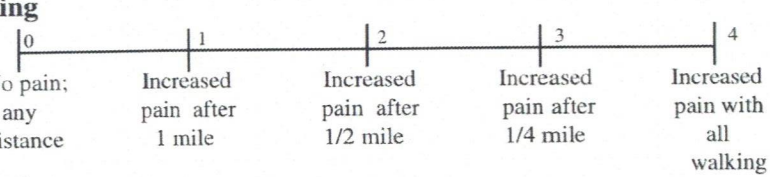
7. Frequency of pain



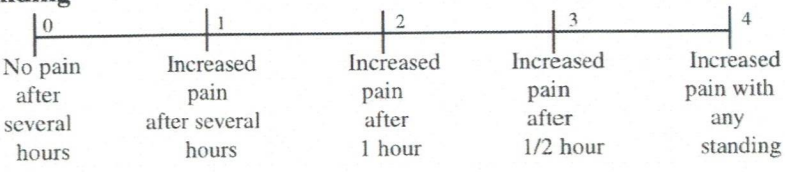
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

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OFFICE POLICY

Dear New Patient:

Welcome to our office! The purpose of these policies are to allow us to better serve you. It is our experience that those patients who adhere to these policies achieve the best results, in the shortest amount of time.

CANCELLATIONS OR CHANGE OF APPOINTMENT TIME

A certain number of treatments in a set amount of time are required to get the results we both desire. If you need to change the time of your appointment, arrange a different tie with the front desk on the same day. If that is not possible, you must make up the missed appointment within the same week. **Missed appointments without a minimum of 24 hour notice, will be subject to charge.**

CANCELLATION NOTICE AND FEES:

We require a 24 hour notice for cancellations or changes to your appointment.
To ensure fairness, we will abide by the same cancellation notice period ensuring we don't cancel your appointment at the last minute.
Cancellations made with less than 24 hour notice will incur a fee of $20 [or 50% of your appointment fee] charged to the card on file.*/**

NO-SHOW FEE:

Missed appointments without prior notice result in a no-show fee of $45 [or 100% of your appointment fee] charged to the card on file. */**

EMERGENCY SITUATIONS:

If unforeseen emergencies require a cancellation, please contact us, and we'll work together to find a solution.

RESCHEDULING OR CANCELLATION:

To reschedule or cancel, please contact us promptly, and we'll accommodate your request based on availability.

Contact information: You can reach us at 504-835-3736 or text us at 504-784-6778 for appointment changes.

By booking with us, you agree to our Cancellation Policy. If you have questions or concerns, don't hesitate to contact us.

*We will be collecting a credit card to keep on file for all patients, no exceptions.
**Regardless of appointment status (Insurance, Private Pay, Auto Accident) you will be responsible for the fees listed above.

RE-EXAMINATIONS AND PROGRESS EVALUATIONS

Periodic re-examinations will take place during your treatment series; usually **every 10-12 visits**. These examinations will enable us to measure your improvement and determine the necessity for further treatment, exercise, nutrition and/or dismissal. An examination will be conducted at the beginning of a new condition, slip, fall, accident, etc. If it has been **6 months or longer since your last visit**, an examination will also be conducted to get an accurate assessment of your condition(s).

CONSULTATIONS

Dr. Theresa L. Harris is more than happy to discuss any problems you may be having. **Please schedule a separate consultation/ conference** time with the front desk to enable the Doctor to give you her full attention and avoid having other patients wait.

REFERRALS

Our office's success depends primarily upon referrals from satisfied patients. We are accepting new patients at this time, and appreciate your referring family, friends and co-workers. For your confidence and trust in our Chiropractic health service, we do **THANK YOU**.

PAYMENTS OF SERVICES RENDERED

Please present your Insurance card to us on your first visit to our office. We will verify your coverage and/or benefits for Chiropractic care, and then file your Insurance claims for you. **You will be responsible for your co-payment or Deductible on each visit.**

AUTO ACCIDENT / PERSONAL INJURY / ATTORNEY

If you were involved in an automobile accident, or hurt yourself and you have an attorney, or someone else's Insurance is supposed to take care of your medical bills, **you will still be responsible for full payment** of your visits here. You must make your own arrangements with your attorney or Insurance Company to reimburse you. Your attorney and/or Insurance companies involved will receive a written (or digital) report from this office regarding your condition, progress and prognosis.

MEDICARE

This office does not accept assignment with Medicare, but we will file your claims for you. You will need to present your Medicare card and your supplemental insurance card to the front desk.

IMPORTANT

Please let us know of any time you are involved in an accident, if you experience an injury, or a new condition. This will enable us to keep your course of treatment running smoothly. If your address, telephone number, or email change, please notify us immediately so we can keep our records current.

We and our staff look forward to assisting you with your health care needs.

Sincerely,
Theresa L. Harris, D.C.

I have read and accept these policies.

_____ _____

PATIENT'S SIGNATURE DATE

_____

WITNESS

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (Print) Date Patient Signature

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IDENTIFICATION OF PERSONS WITH AUTHORIZATION OF ACCESS TO PATIENT HEALTH INFORMATION

Those individuals or parties that could have access to Patient Health Information at Harris Sports and Family Chiropractic Office include but may not be limited to:

1. The staff of Harris Sports and Family Chiropractic Office
2. Ralph Rodgers, Computer Technician (IT)

AUTHORIZATION FOR RELEASE OF MEDICAL AND FINANCIAL INFORMATION

I authorize the release of my medical records, financial and insurance information to the following people: (Necessary health care provider or vendors who may need to be consulted if related to the patient's condition. Also for family members or friends that the patient authorizes to have access to this information as well.)

	NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

PRINT NAME: _____ DATE: _____

SIGNATURE: _____