Strickland Chiropractic Clinic, Inc.
4935 Century Street NW, Suite 101, Huntsville, AL 35816

Case # ______________ Date ________________

Name: ____ Home Phone: ______________________
(Last) (First) (MI)

Cell Phone: ________________________

Address: ____
(Street) (City) (State) (Zip)

Would you like to receive emails? ☐ Yes ☐ No E-mail: ____

Age: _________ Date of Birth: ____________________________ Social Security #: _____-______-______

Place of Employment: ____ Work Phone: _____________________

In case of emergency, please contact: ____ Phone ____________________

What is your reason for coming to our clinic? ____

____

Have you ever been seen by a chiropractor before today? Yes ☐ No ☐

How did you choose our clinic? Phone Book ☐ Friend ☐ Family ☐ ART Website ☐

Who may we thank for this referral? ____

Do you have insurance that you wish to use? Yes ☐ If so, Name:______________________________ No ☐

Payment is *expected* in FULL when services are rendered, unless other arrangements are made in advance. Please feel free to ask any questions that you may have concerning our office policies.

<u>Assignment, lien, authorization for insurance benefits</u>. If this account is turned over to an attorney for collection, I agree to pay all costs of collection, including reasonable attorney fees.

I HEREBY AUTHORIZE AND DIRECT YOU, MY INSURANCE COMPANY, AND/OR MY ATTORNEY TO PAY DIRECTLY TO DR. KENNETH STRICKLAND AND/OR DR. SANDRA STRICKLAND, SUCH SUMS AS MAY BE DUE AND OWING TO THIS OFFICE FOR SERVICES RENDERED TO ME, BOTH BY REASON OF ACCIDENT QR BY REASON OF ANY BILLS THAT ARE DUE TO THIS OFFICE, AND TO WITHHOLD SUMS FROM AND DISABILITY BENEFITS, WORKERS COMPENSATION BENEFITS, NO FAULT BENEFIT OR ANY BENEFIT OBLIGATED TO REIMBURSE ME FROM ANY SETTLEMENT. I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE GRAND TOTAL AMOUNTS DUE TO THE OFFICE FOR SERVICES RENDERED. I HEREBY STATE THAT A PHOTOCOPY OF THIS DOCUMENT WILL BE DEEMED AS VALID AND BINDING ON ALL PARTIES AS THE ORIGINAL COPY.

Patient Signature (patient Guardian): ____

Witnessed by: ____

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HISTORY & PHYSICAL

Patient Name: ____
(Last) (First) (MI)

Date of Birth: ____________ Age: _______ Male ☐ Female ☐ Married ☐ Single ☐ Other ☐

Family Physician: __________________________ Date of last physical: ____/____/____
Were there any abnormal findings? If so, please describe ______________________________
____

Social History

Do you smoke?	Yes ☐	No ☐	Packs per day _______
Do you drink alcoholic beverages?	Yes ☐	No ☐	Drinks per day _______
Are you allergic to any latex products?	Yes ☐	No ☐	
Are you allergic to any medications?	Yes ☐	No ☐	

Please list all medications you are allergic to:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

List all medications you are currently taking:

Medications	Dosage	Times/Day

Previous operations or hospitalizations:

Date	Hospital	Reason

In the past 2 years have you had any MRI's, CT's, Bone Scans, X-Rays or any other diagnostic testing? If yes

When	Where	What

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Do You Have or Have You Had Recently (Please circle yes or no)

EYE/EAR			**NOSE/THROAT/NECK**			**CARDIOVASCULAR**		
Glaucoma	Yes	No	Hoarseness	Yes	No	Chest Pain	Yes	No
Cataracts	Yes	No	Change in Voice	Yes	No	Irregular Heartbeat	Yes	No
Glasses/Contacts	Yes	No	Nose Bleed	Yes	No	Low Blood Pressure	Yes	No
Loss of Hearing	Yes	No	Thyroid	Yes	No	High Blood Pressure	Yes	No
Hearing Aids	Yes	No				Heart Attack	Yes	No

RESPIRATORY			**GASTROINTESTINAL**			**URINARY**		
Asthma	Yes	No	Stomach Ulcers	Yes	No	Bloody Urine	Yes	No
Wheezing	Yes	No	Gallbladder Trouble	Yes	No	Frequent Urine	Yes	No
Shortness of Breath	Yes	No	Pancreatitis	Yes	No	Nighttime urination	Yes	No
Pain with Breathing	Yes	No	Colitis	Yes	No	Trouble starting	Yes	No
Coughing up Blood	Yes	No	Blood in Stool	Yes	No	Trouble stopping	Yes	No
			Hiatal Hernia	Yes	No	Pain with urination	Yes	No
			Liver Trouble	Yes	No	Prostate Problems	Yes	No

GENITAL			**NEUROLOGICAL**			**SKIN**		
Sores on genitals	Yes	No	Headaches	Yes	No	Infections	Yes	No
Infections	Yes	No	Fainting/Blackouts	Yes	No	Psoriasis	Yes	No
Herpes	Yes	No	Seizures/Epilepsy	Yes	No	Skin Cancer	Yes	No
AIDS	Yes	No	Strokes	Yes	No	Rashes	Yes	No
AIDS related disease	Yes	No	Paralysis	Yes	No			

METABOLIC			**BLEEDING DISORDER**			**FEMALE MEDICAL HISTORY**		
Diabetes	Yes	No	Anemia	Yes	No	Are you pregnant?	Yes	No
Low Blood Sugar	Yes	No	Bleeding	Yes	No	Are you on the pill?	Yes	No
						Date of last cycle?		
						Postmenopausal	Yes	No
						Number of years		

Have you ever been diagnosed with cancer? Yes ☐ No ☐
If yes, please describe: ______________________________

Bone & Joint		
Arthritis	Yes	No
Rheumatoid Arthritis	Yes	No
Gout	Yes	No
Lupus	Yes	No
Osteoarthritis	Yes	No

FAMILY HISTORY		
Diabetes	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Strokes	Yes	No
Tuberculosis	Yes	No

Physical Exam (doctor only)
General:

Psychological Status:

Heart:

Lungs:

Other Findings:

Patient Signature/Guardian: ______________________________

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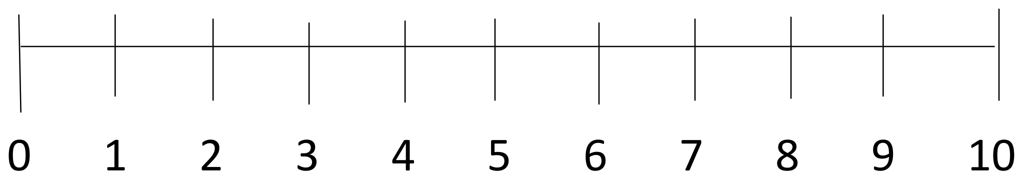
VISUAL ANALOG PAIN SCALE



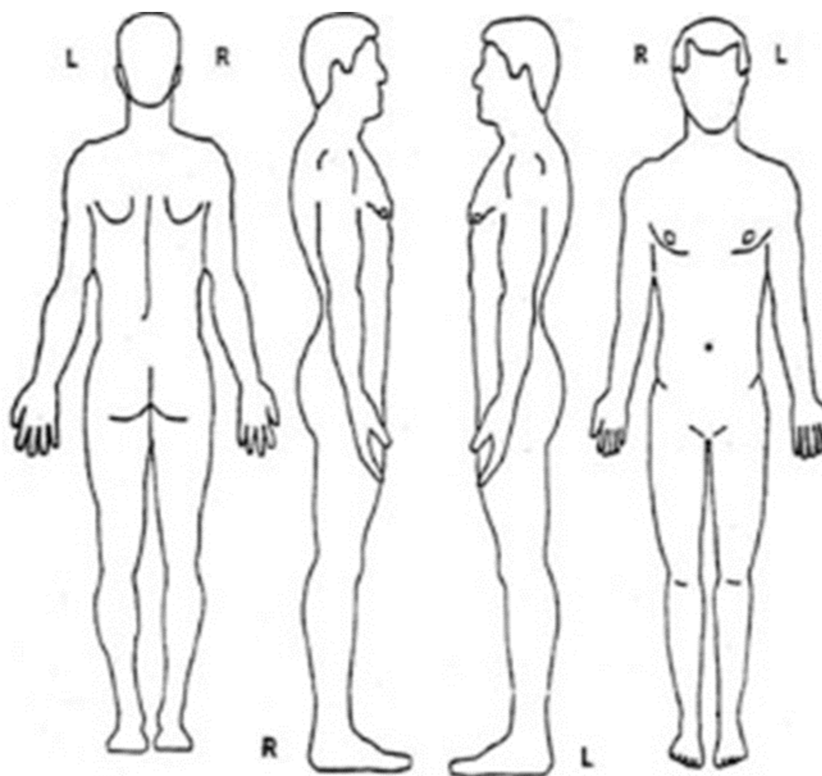
0 1 2 3 4 5 6 7 8 9 10

No pain

Worst pain

Tell us where you hurt. Please read carefully.
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use appropriate letters as listed below.

Ache – A Numbness – N Pins/Needles – P Burning – B Stabbing – S Throbbing - T



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Consent to Chiropractic Manipulation and Care

I (we) hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures that may include acupuncture on me by Kenneth B. Strickland, D.C or by Sandra L. Strickland, D.C.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complication associated with chiropractic services is very low, anyone undergoing manipulative procedures, physical therapy or rehabilitation should know that possible hazards and complications which may be encountered or result. These include but are not limited to fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. Acupuncture treatment may cause some localized soreness, bruising and/or bleeding.

I have read or have been read the above consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the names procedures.

Patient Name (please print): ______________________________

Patient Signature: ______________________________ Date ______________
Guardian Signature if patient is a minor and relationship

Authorizations

As required by the Health Insurance Portability and Accountability Act of 1996, Strickland Chiropractic Clinic may not use or disclose your health information except as provided in the Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and/or disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

I, ______________________ (print name) hereby authorize the Strickland Chiropractic Clinic of the following health information that pertains to me: 1) filing health insurance claims; 2) Releasing patient information to insurance companies, i.e. patient records, tests, procedures and x-rays; 3) Correspondence with other physicians or health care providers; 4) Attorneys
For the following purposes: 1) Reimbursement of claims made; 2) Records inspections/review; 3) Collections; 4) Court appearance. I authorize Dr. Kenneth B. Strickland and/or Dr. Sandra L. Strickland to make these disclosures on my behalf.

I authorize the following persons to receive these disclosures of my health information: 1) Insurance Companies; 2) Correspondence with other physicians or health care providers; 3) Attorneys and/or officers of the court.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Strickland Chiropractic Clinic. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my ability for benefits will not depend in any way on whether I sign this authorization or not. However, I understand that if I choose to not sign this agreement I am fully responsible for all charges incurred. I understand that I have a right to inspect and to obtain a copy of any information pursuant to this authorization.

Patient Signature: ______________________________ Date: ______________

- -

REVOCATION

Patient Signature: ______________________________ Date: ______________

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NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly full schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.

Your no show fee must be paid prior to your next appointment.

If you are 15 minutes past your scheduled time you will have to wait until there is an opening in the schedule to be seen.

______________________________ ______________________________
Signature of patient Name of patient or representative (please print)

______________________________ ______________________________
Date Relationship to patient (or other authority to serve)

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INSURANCE/FINANCIAL AGREEMENT

To the extent necessary to determine liability and to obtain reimbursement, I authorize disclosure of my medical records to my insurance carrier. Medigap carriers, and/or such other persons or entities which may be responsible for payment, in whole or in part. I hereby assign all medical benefits and payments to Kenneth Strickland, D.C., C.C.S.P., and/or Sandy Strickland, D.C. More specifically, in the event that I am entitled to any type of medical benefits arising out of policy insurance and benefits, I hereby agree that SCC (Strickland Chiropractic Clinic) and/or such physician may retrieve any such payment. I agree that in return for the services provided to the patient by SCC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to SCC for payment. If an account is sent to a collection agency or an attorney's office for collection on a past due balance, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that, if my account is delinquent I may be charged interest at the legal rate. Any benefits, of any type, under any policy insurance insuring the patient, or any other party liable to the patient are hereby assigned to SCC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to SCC; however, it is understood that the undersigned and/or patient is primarily responsible for the payment of my bill.

____________________________	________________________
Signature of patient	Date

MEDICARE ASSIGNMENT/SIGNATURE ON FILE/FINANCIAL AGREEMENT

I request that payment of authorized Medicare benefits be made on my behalf to SCC for services furnished by SCC. I authorize any material information about me to be released to the Centers for Medicare and Medicaid Services (CMS) and its agents, any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. SCC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I agree that in return for the services provided to the patient by Strickland Chiropractic Clinic (SCC), I will pay my account at the time service is rendered or will make financial arrangements satisfactory to SCC for payment. If an account is sent to an attorney for collections, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that, if my account is delinquent I may be charged interest at legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient are hereby assigned to SCC. If co-payments and/or deductible are designated by my insurance company or health plan, I agree to pay them to SCC; however, it is understood that the undersigned and/or the patient is primarily responsible for the payment of my bill.

____________________________	________________________
Signature of patient	Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I, ____, acknowledge that I have received a copy of the notice of privacy practices.

____	____
Signature of patient	Name of patient or representative (please print)
____	____
Date	Relationship to patient (or other authority to serve)

If patient or personal representative is unable or refuses to sign the form, document the reasons on this form. Place this form in the patient's medical record.

You have the right to review or request copies of your medical records at any time. We request that you give us up to 24 hours to accommodate your request.

I give permission for information to be left on my answering machine/voicemail at the following number:

____.

I authorize the staff of Strickland Chiropractic Clinic to discuss my care with the following people:

Name ____ Phone ____________________________

Name ____ Phone ____________________________