LOUISVILLE FAMILY CHIROPRACTIC

8117 New LaGrange Road
Louisville, KY 40222
502-326-9950

Please thoroughly complete all questions for your application for care. If the question does not apply to you please answer N/A. Thank you!

Name: _____Today's Date:_____

Address: _____City/State/Zip: _____

E-Mail: _____ Home #: _____ Work #:_____ Cell #: _____

For appointment reminders what is your preferred method of communication: Email or Text

For reminders: Cell phone carrier: _____
How long before your appointment would you like your reminder sent to you? (Circle one)

15 minutes	1 hour	1 day
30 minutes	2 hours	
45 minutes	4 hours	

Marital status: M/W/D/S Birth date:____/____/____ Age: _____ Social Security #:_____

Estimated Due Date:_____
Did a health problem prompt you to visit a chiropractor?_____Explain_____
_____
_____
What symptoms of pregnancy have you already experienced?_____
_____
Previous Major Illness or Surgery_____
_____
Medications you are currently taken or have taken since conception:_____
_____
Do you smoke? _____ (If no, did you ever smoke)?_____ How Long_____
Do you drink? None _____Social (Fewer then 2 daily) _____Heavy (2 or more daily)_____
List the foods you eat daily and summary of your diet habits _____
_____
_____
What type of exercises do you do? _____
_____
Age at last menstrual cycle? _____Length of regular menstrual cycle? _____

Are your cycles regular? Always _____Most of the time_____Never _____
Date of your last menstrual cycle _____Was it normal? _____
Date of last x-rays if any? _____Why and by whom? _____
Have you had any previous pregnancies?_____Explain _____
_____
Have you had past cesareans? _____ How many?_____
Have you had a previous D&C?_____How many and dates? _____
Do you have any of the following?
Diabetes_____Asthma_____Rh negative blood_____Other chronic problems_____
Have you taken birth control pills?_____Type _____
Have you used an IUD?_____Date of removal_____
Did you have any health problems during previous pregnancies? Explain _____
_____
Have you ever received chiropractic care?_____Dr's. Name:_____
Results_____
Who referred you to our office?_____
Name of your obstetrician/Midwife?_____
Doula_____
Which child birth class will you or have you taken? _____
Where do you plan to have your baby? _____
Additional comments_____
_____
_____

To be in compliance with requirements for the government EHR incentive program, please answer the following questions.

Smoking Status (circle one): Every day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Preferred Language:_____

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (Please include regularly used over the counter medications/supplements) (If you need additional space, please write on back of form)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

□ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Do you have health insurance? _____ Name of company: _____
Policy Holder: _____ ID#: _____
Policy Holder's Date of Birth: ____/____/_____ Relationship to Patient:_____

Method of payment for first visit:
_____Cash _____Check _____MAC _____Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ Date: ____/_____/_____

Louisville Family Chiropractic
8117 New LaGrange Rd.
Louisville, KY 40222
Phone: 502-326-9950
health@lfchiro.net

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Louisville Family Chiropractic (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the above address, Attention: Practice Compliance Director.
4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions:_____

   I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations. By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient's Name (please print) Date of Birth

_____ _____
Name of Personal Representative Relationship to Patient

To Be Completed by the Practice
The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:
___Accepted _____Denied ___ Not Applicable _____Other (explain)_____

_____
Signature of Authorized Practice Representative Date

LOUISVILLE FAMILY CHIROPRACTIC
Authorization, Assignment, Consent to Treat and Medical Release

In consideration of you undertaking to treat me, I agree to the following:

MEDICAL RELEASE/FINANCIAL POLICY

LFC is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by the patient. All charges incurred by the patient or dependents is the patients responsibility, if insurance does not pay, the patient is responsible for the balance.

ASSIGNMENT OF BENEFITS

I authorize the direct payment to you of any sum I now and hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to compromise, settle or otherwise resolve this claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds (whether it be part or all of what is due), I personally owe to you.

AUTHORIZATION

I, the undersigned, do hereby appoint Louisville Family Chiropractic, and any of its duly authorized agents, to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned above or as co-payee with Louisville Family Chiropractic when said payments are due for services rendered on behalf of the undersigned by the clinic.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and that Louisville Family Chiropractic doctor(s) and his/her associates have my permission to perform an x-ray examination. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period ___/___/___. (initial _____)

CONSENT TO TREAT

I, the undersigned, do hereby authorize Louisville Family Chiropractic, (and whomever may be designated as assistants) to administer such examinations, treatments and care, as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original

_____

Date Patient's Signature Witness Signature

Louisville Family Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, it during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Patient's name)

_____ _____
Signature Date