

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Sex  M  F Birthdate \_\_\_\_\_  
last first middle initial

Address \_\_\_\_\_  
street/p.o. box city state zip

Marital Status  Single  Married  Widowed  Separated  Divorced

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Phone \_\_\_\_\_ Email address: \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
last middle initial first

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

## EMPLOYER INFORMATION

Employer \_\_\_\_\_

Address \_\_\_\_\_  
street/p.o. box city state zip

Phone \_\_\_\_\_

## SPOUSE/PARENT INFORMATION

Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## PATIENT CONDITION

Reason for visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Mark an X on the picture where you experience pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). \_\_\_\_\_

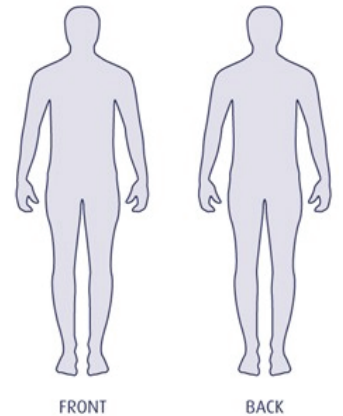
Type of pain (check all that apply)  Sharp  Dull  Throbbing  Numbness  Aching  
 Shooting  Burning  Tingling  Cramps  Stiffness  
 Swelling  Other: \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with (check all that apply)  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform (check all that apply)  Sitting  Standing  Walking  Bending  Lying Down



## HEALTH HISTORY

What treatment have you already received for this condition?

Medications  Surgery  Physical Therapy  Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition

Date of last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |   |   |   |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No        | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No          | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No         | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No       | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No        | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No   | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No         | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No                | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No           | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No        | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No             | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  | Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No    | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No   | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No           | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No                | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No   | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No           | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     | Other _____   |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No           | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No   | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | _____   |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No    | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No      | _____   |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No         | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No          |   |   |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No         |   |   |
|  | Headaches   |   |   |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking  
 Alcohol  
 Coffee/Caffeine Drinks  
 High Stress Level

Packs per day \_\_\_\_\_  
 Drinks per week \_\_\_\_\_  
 Cups per day \_\_\_\_\_  
 Reason \_\_\_\_\_

Are you pregnant?  Yes  No if so, Due date: \_\_\_\_\_

INJURIES/SURGERIES YOU HAVE HAD	description	date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## INSURANCE INFORMATION

*\* If this is a personal injury assignment, please skip to "Personal Injury Information"*

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Member Number \_\_\_\_\_ Group \_\_\_\_\_

Is patient covered by additional insurance?    Yes    No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Member Number \_\_\_\_\_ Group \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Damon Butler all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party Signature

Relationship to Patient \_\_\_\_\_

## ACCIDENT INFORMATION

What was the date of the accident?

Type of accident \_\_\_\_\_

## \* PERSONAL INJURY INFORMATION

Attorney Name OR Insurance Adjustor \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email address: \_\_\_\_\_

Responsible Insurance Company \_\_\_\_\_

Claim Number \_\_\_\_\_

Insured \_\_\_\_\_

street/p.o. box

city

state

zip

Patient's Auto Insurance Company \_\_\_\_\_

Primary Phone \_\_\_\_\_ Email address \_\_\_\_\_

Policy \_\_\_\_\_

Will will accept assignment from your attorney for your chiropractic treatment. We will supply your attorney with an evaluation of your condition, progress reports, and final evaluation along with your bill. You are responsible for your bill if you dismiss your attorney or if this office is not paid directly by your attorney or the responsible insurance company.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT HEALTH INFORMATION CONSENT

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 or 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.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Central Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Central Chiropractic Center to use and/or disclose all medical records and bills to the entities below:

REQUESTOR NAME: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ D.O.A.: \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

This authorization shall expire upon this expiration date: \_\_\_\_\_.  
If I fail to specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Central Chiropractic Center. I understand that the revocation will not apply to information that has already been released to this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may refuse to sign this authorization and it is strictly voluntary.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

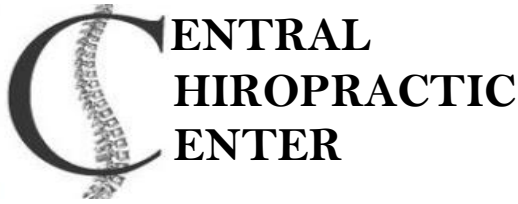
**I have read the above and authorize the disclosure of the protected health information as stated.**

**A photocopy of this authorization is to be accepted and given the same effect as the original.**

\_\_\_\_\_  
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date



**CENTRAL  
HIIROPRACTIC  
CENTER**

**Dr. Damon C. Butler**

*Chiropractic Physician*

**GOOD FAITH ESTIMATE**  
**Cash/Out of Network Patients**

We are pleased to have you as a patient. We understand that medical expenses can become very costly. It is our top priority to provide you with the highest level of care possible at an affordable price. There are certain costs associated with your daily treatment that you are responsible for paying at the time of treatment.

An itemized list of items or services that are “reasonably expected” to be furnished:

**99202-99203**

**Initial Evaluation - \$110**

Includes a full evaluation of the patient, Spinal Manipulation, and therapy.  
May also include electrical muscle stimulation, ultrasound and ice/heat pack.

**72040-72100**

**X-rays - \$70**

**98940-98943**

**Regular Office Visit - \$55**

Includes Spinal Manipulation and therapy (electrical muscle stimulation, ultrasound and ice-heat pack) **97012-97018, 97035, G0283**

TOTAL ESTIMATED CHARGES\*: \$180 INITIAL with xrays \$110 without xrays  
\$55 REGULAR VISITS

*\*This is an estimated cost only covering date stated. More (or less) visits may be needed.*

If your condition requires other (outside) testing, such as an MRI or Lab you will receive a separate estimate and billing directly from them. You will be responsible for any extra services incurred for that visit.

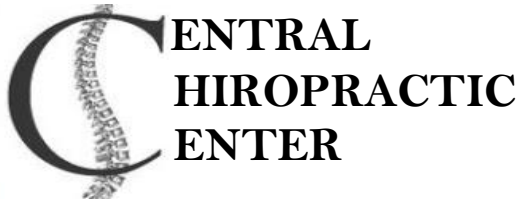
By signing below you acknowledge that you understand and agree with the above policy and the responsibility for your bill. (These costs are valid for 12 months from the date of the Good Faith Estimate).

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

Date of Visit: \_\_\_\_\_ This estimate covers dates thru: \_\_\_\_\_



**Dr. Damon C. Butler**

*Chiropractic Physician*

***Please Note:***

- Disclaimer: there may be other services required that must be scheduled separately during the course of treatment and are not included in the Good Faith Estimate (GFE)
- Disclaimer: this is only an estimate and actual services, and charges may differ
- Disclaimer: GFE is not a contract, and the patient is not required to obtain services from this provider
- You have the right to receive a “Good Faith Estimate” explaining how much your medical health care will cost.
- Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services
- You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises).
- Complaints about medical billing - You can submit a complaint about a medical billing experience you had, whether you’re insured or uninsured.  
<https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing>