Confidential Patient Information

Please print clearly.

Last Name: ______________________ First Name: ____________________ Middle: __________

Date of Birth: ____/_____/_________ Male ☐ Female ☐ SSN: _____ - ____ - ______

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner ☐

Mailing Address ____

City ______________________ State ______ Zip __________ Work Phone: (____) ____ - ______ Ext ____

Home Phone: (_____) ______ - ________ Cell Phone: (_____) ______ - ________ Carrier ______________

Email: ____

When checking in on our kiosk which number would you prefer to check in with?

Home ☐ Cell ☐ Work ☐ Password ☐

Emergency Contact Info: Name: ___________________________ Phone: (____)_____-________

Are your symptoms related to a motor vehicle accident or a work injury? ☐ Yes ☐ No

Insurance Information:

Please provide the front desk with your insurance card. If you have secondary insurance coverage please inform front desk.

Name of insurance: ___________________________ Subscribers Name:_____________________

Subscribers birthdate_____/______/__________ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Information:

Name of insurance: ___________________________ Subscribers Name: _____________________

Subscribers birthdate_____/______/__________ Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Date of Onset OR Injury _______/_________/_________

Authorizations:

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits of Martha Lake Chiropractic / Dr. Lawrence Ball

I authorize payment of any medical benefits from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree the health and accident policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that paid directly to this office will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Signature: ____________________________________ **Date:** _____/_______/_______

Guardian Signature: ___________________________________ **Date:** _____/_______/_______

Massage No-Show and Late Arrival Policy

Cancelation/No-Show Policy

If you are unable to make it to your appointment it is important for you to call to cancel or reschedule your appointment time. For any **massage** appointment you do not show up to or cancel less than **24 hours** prior to the start of your appointment time, you will be charged a **$80.00 fee**. This must be paid prior to your next appointment.

Initial: ___________

Showing Up Late

If you anticipate you will be late for your appointment, please call us and let us know. Depending on how late you arrive, we will determine if we will be able to get you in or you may be subject to **the late/cancelation/no-show fee** as stated below.

15 to 30 minutes late: **$20.00 fee**
31 to 45 minutes late: **$40.00 fee**
Over 45 minutes late: **$80.00 fee (whole no show fee)**

Please understand that when you are late for a massage appointment, we can only bill your insurance for the length of treatment you receive. For this reason, you will be responsible for the difference between our massage price and the amount we can bill to your insurance according to the fee schedule above.

Please arrive 10 minutes prior to your appointment to allow time to check in unless otherwise instructed.

By signing below, you are acknowledging that you have read, understand, and agree to all of the information on this form.

Print Name: ______________________________

Signature: ______________________________ **Date:** ________________

Martha
Lake
Chiropractic
& Wellness

Massage Health Information

Patient Name: ______________________________ **Date:** __________________________

List and explain, please include dates and treatment received:

Surgeries: ____

Accidents: ____

Major Illness: ____

Current Health Issues and Concerns: ____

List daily activities:

Work ______________________________ Home/Family ______________________________

Social/Recreational ______________________________ Sleep Habits ______________________________

Check current or previous conditions:

Now	Past		Now	Past	
☐	☐	Headaches			
☐	☐	Pain	☐	☐	Fever
☐	☐	Sleep disturbances	☐	☐	Sinus problems
☐	☐	Fatigue			

On a scale of 1 (best) to 10 (worst) rate the level of pain: __________

Describe the type of pain that you are experiencing: ____

____

List any medications you have taken in the last ten days. (Include pain relievers, herbal remedies, over the counter medications and prescriptions): ____

Contract for Care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and the other members of my health care team, and my experience of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner anytime I feel my wellbeing is threatened or compromised. I expect my manual therapist to provide safe and effecting

Consent for Care:

It is my choice to receive manual therapy and I will give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Patient Signature: ____

Martha Lake
Chiropractic
& Wellness

Massage Health Checklist

Please check ☑ current and previous conditions

General

Now Past
- ☐ ☐ Headaches
- ☐ ☐ Pain
- ☐ ☐ Sleep Disturbances
- ☐ ☐ Fatigue
- ☐ ☐ Infections
- ☐ ☐ Fever
- ☐ ☐ Sinus Problems
- ☐ ☐ Rash
- ☐ ☐ Athletes foot/warts
- ☐ ☐ Other: ________________

Allergies

Now Past
- ☐ ☐ Nuts
- ☐ ☐ Scents/lotion/detergent
- ☐ ☐ Other: ________________

Respiratory/Cardiovascular

Now Past
- ☐ ☐ Heart Disease
- ☐ ☐ Blood clots
- ☐ ☐ Stroke
- ☐ ☐ Lymphedema
- ☐ ☐ High/Low blood pressure
- ☐ ☐ Irregular heart beat
- ☐ ☐ Poor circulation
- ☐ ☐ Swollen ankles
- ☐ ☐ Varicose veins
- ☐ ☐ Chest pain
- ☐ ☐ Asthma

Head Injuries

Now Past
- ☐ ☐ Head injuries
- ☐ ☐ Dizziness/ringing in ears
- ☐ ☐ Memory loss/confusion
- ☐ ☐ Numbness/tingling
- ☐ ☐ Scatia/shooting pain
- ☐ ☐ Chronic pain
- ☐ ☐ Depression
- ☐ ☐ Other: ________________

Muscles/Joints

Now Past
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Osteoarthritis
- ☐ ☐ Scoliosis
- ☐ ☐ Broken bone
- ☐ ☐ Spinal problems
- ☐ ☐ Disc problems
- ☐ ☐ Lupus
- ☐ ☐ TMJD/jaw pain
- ☐ ☐ Spasms/cramps
- ☐ ☐ Sprains/strains
- ☐ ☐ Tendonitis/bursitis
- ☐ ☐ Stiff/painful joints
- ☐ ☐ Weak/sore muscles
- ☐ ☐ Neck/shoulder/arm pain
- ☐ ☐ Low back/hip/leg pain

Digestion

Now Past
- ☐ ☐ Bowel dysfunction
- ☐ ☐ Gas/bloating
- ☐ ☐ Bladder/kidney dysfunction
- ☐ ☐ Abdominal pain
- ☐ ☐ Other: ________________

Endocrine

Now Past
- ☐ ☐ Thyroid dysfunction
- ☐ ☐ Diabetes

Reproductive System

Now Past
- ☐ ☐ Pregnancy
- ☐ ☐ Painful/emotional menses
- ☐ ☐ Fibrotic cysts

Cancer/Tumor

Now Past
- ☐ ☐ Benign
- ☐ ☐ Malignant

Acknowledgement of Receipt of HIPAA Privacy Practices

By signing this form, I acknowledge that I have received a copy of the **Martha Lake Chiropractic Center** Patient Notice of Privacy Practices effective May 02, 2016. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care of providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditations.

Patient Name: ______________________________________

Signature: ____________________________________ Date: ________________________
(or Guardian, if applicable)

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify): ____

____

Staff signature: ________________________________ Date: ________________________