

Timothy P. Kelly D.C.
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NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and Medicare card (if applicable).

PLEASE PRINT CLEARLY

Full Name: _____ **E-mail:** _____ **Gender:** M__ F__ **Age:** ____ **Birth Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security #: ____ - ____ - ____ **Driver's License #:** _____ **Home Phone:** (____) _____

Marital Status: __ S __ M __ D __ W **# of Children:** ____ **Work Status:** __ Full-Time __ Part-Time __ Retired **Cell Phone:**(____) _____

Females: Last Menstrual Period: _____ **Pregnant?** __ Y __ N **Nursing?** __ Y __ N **Fax:** (____) _____

Employer: _____ **Occupation:** _____ **Work Phone:** (____) _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name of Spouse, Parent or Guardian: _____ **Age:** ____ **Birth Date:** _____ **SS#:** ____ - ____ - ____

Spouse's Employer: _____ **Spouse's Occupation:** _____ **Work Phone:** (____) _____

In Case of an Emergency Contact: _____ **Relationship:** _____

Home Phone: (____) _____ **Cell Phone:** (____) _____ **Work Phone:** (____) _____

Do you have Medicare Insurance? __ Y __ N **Plan/Group #:** _____ **Medicare card copies by Office Staff** ____

How did you hear about our clinic? _____ Whom may we thank for referring you? _____

How will payment be made?

__ Cash __ Check __ Credit Card __ Driver's License copies by Office Staff __ Insurance Card copies by Office Staff

Who is responsible for payment? _____

Insurance Company: _____ Policy Number: _____

Address: _____ Phone Number: _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care 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 PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations (03/30)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Timothy P. Kelly, D.C.

I consent to the use or disclosure of my protected health information by Chiropractor for the use of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the full right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However is Chiropractor agree to a restriction that I request in writing, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have the right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy of Chiropractor describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Representative

Printed Name

Description of Representative

Date

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

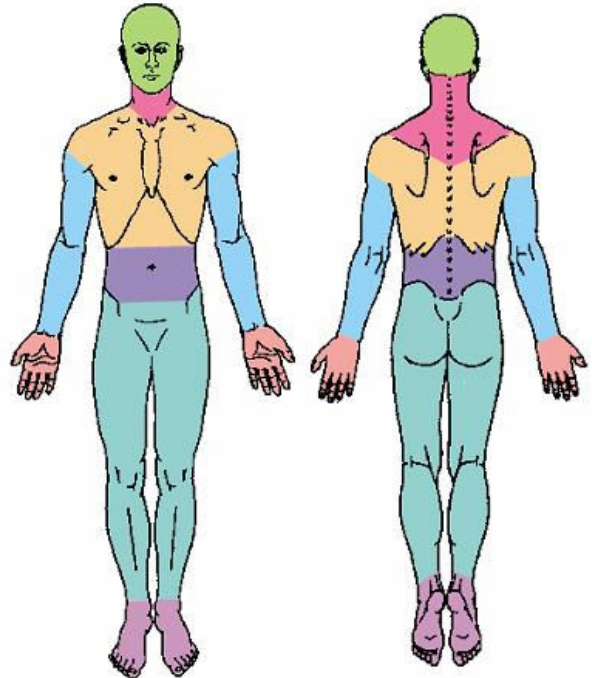
- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

Complaint/ Problem: In relation to your primary complain:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition? Y N
 If yes, whom? _____ Treatment(s): _____
 Have you had any intolerance or reactions to treatment? Y N Describe: _____
 If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____ Has it become worse recently? Y N Same Better Gradually worse
 How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All Day Few hours Minutes
 Is this condition interfering with your: Work Sleep Daily routine Recreation Other: _____
 How long has it been since you felt really good? Days Weeks Months Years > 10 years
 Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
 What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
 Is there anything that you can do to relieve the problem? Y N If yes, describe: _____
 If no, what have you tried to do that has not helped? _____
 What do you believe is wrong with you? _____
 Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____
 Have you been in an auto accident? Past year Past 5 years Over 5 years Never
 Describe: _____

Please check all that apply. (P=Past / C=Current)

- | P/C | P/C | P/C |
|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Sore Muscles |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Impatience |
| <input type="checkbox"/> Unpleasant Odor | <input type="checkbox"/> Elbow / Hand Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Hip Pain | _____ |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Knee Pain | _____ |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Poor Circulation | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Swollen Joints | |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Ankle / Foot Pain | |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Low Back Pain | |



ALLERGIES: Please check and list all allergies.

____ Food: _____

____ Medication: _____

____ Seasonal / Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	<u>Medication Name</u>	<u>Date Started</u>
Antacids		
Antibiotics		
Antidepressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Lowering Meds		
Cholesterol Lowering Meds		
Hormone Replacement (HRT)		
Oral Contraceptives		
Other		

Scars / Surgical Procedures: List all scars and surgical procedures you have had. _____

Supplements: Do you take Vitamins/Supplements or herbs? Y N If yes do you recommend them? _____

Habits:	Heavy	Moderate	Light	None							
Alcohol	_____	_____	_____	_____	<u>Exercise</u>	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Coffee	_____	_____	_____	_____		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Soda/Diet Soda	_____	_____	_____	_____	<u>Sleep</u>						
Tobacco	_____	_____	_____	_____		5+	4	3	2		
Drugs	_____	_____	_____	_____	<u>Meals / Day</u>						
Stress Level	_____	_____	_____	_____		64+ oz	32-64 oz	16-32 oz	<8oz		
					<u>Water / Day</u>						

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking / Moving Driving

Family History: Identify any condition that you or any of your family members have now or have had in the past:
(G=Grandmother, M=Mother, F=Father, S= Siblings, X= Self)

- | | | | |
|---|--|--|--------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | _____ |
| Other: _____ | | | |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | |
| _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Deep vein thrombosis | | | |
| <input type="checkbox"/> Detached Retina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stroke | |

I have read and understood all of the above questions and all of the information I have given is accurate to the best of my knowledge. Furthermore, I understand that the chiropractic spinal adjustment and care I receive in this office are not replacement for any form of diagnosis or treatment provided by other practioners. I accept that the chiropractic care is a form of wellness care to promote health and the natural healing mechanism in accordance with the scope of practice of a Doctor of Chiropractic.

Patient's Signature

Date

● **AUTHORIZATION AND ASSIGNMENT – Timothy P. Kelly, DC**

Authorization for Treatment:

I hereby authorize Timothy P. Kelly, DC, and his staff to perform any and all acts within the scope of Chiropractic which they deem would be beneficial for me. I authorize them to release my information acquired in the course of my examination or treatment to my insurance company, attorney or other doctor. I give permission for my address, phone number and clinical records to be used to contact me with appointment reminders, missed appointment notification, birthday or holiday cards, information about treatment alternatives or other health related information. I give permission for Timothy P. Kelly and staff to leave messages on my answering machine or voice mail at home, work or cell phone.

Consent to Treat a Minor:

I hereby authorize Timothy P. Kelly, DC, to tender any form of treatment of Chiropractic as permitted by law and which in their sole discretion would benefit my minor child. _____

Pregnancy Declaration:

I verify that my last menstrual period was _____ and that I am not pregnant. Timothy P. Kelly, DC, and staff have been informed of my condition and are not responsible for any problems as a result of diagnostic x-rays taken.

Payment Policy:

We accept cash, check, Visa, MasterCard, American Express, and Discover. Payment is due at time of service, unless a payment arrangement is made with the office manager. If insurance is being filed, co-pays and any deductibles are due at time of service.

When possible, please give 24 hours notice when you need to cancel your appointment. Although we don't generally charge for missed appointments, continuous no shows, without calling, may result in a minimal office charge of \$50.

Assignment of Payment:

I hereby authorize and direct my insurance company and/or attorney to pay Timothy P. Kelly, DC, any monies due him on my account. I hereby, further, give a lien on my case to said doctor against any and all proceeds of my settlement as the result of the injuries for which I am treated. This payment shall be made first before all other payment obligations.

I fully understand that I am directly and fully responsible for all medical bills for services rendered to me, and this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I have read and understood how my Patient Health Information will be used and I agree to the policies and procedures of this office.

Name of Patient: _____

Signature of Patient/Parent/Guardian _____

Date: _____ **Relationship to Patient:** _____