Fields CHIROPRACTIC

REGISTRATION AND HISTORY

Patient Information

Date: _____

Last Name: _____

First Name: _____ M.I. ____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Email: _____

Would you like to receive billing notification via email? ☐ YES ☐ NO

Home: _____ Work: _____

Cell: _____ Other: _____

Birthdate: _____ Sex: ○Male ○Female

SSN: _____

Marital Status: ○Single ○Married ○Divorced ○Separated ○Partnered

Race: _____ Ethnicity: _____

Occupation: _____

Responsible Party

If you have insurance in someone else's name, please list that information here

Name: _____

Relationship: _____

SSN: _____

Birthdate: _____

Phone Number: _____

Insurance Assignment and Release

I certify that I, and/or my dependents have insurance coverage and assign directly to **Fields Chiropractic Clinics, P.A.** All insurance benefits are payable to this clinic for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that it is the policy holder's responsibility to verify coverage for services rendered. I authorize the use of my signature on all insurance submissions. Copayments, coinsurances, and deductible amounts are due at time services are rendered.

Fields Chiropractic Clinics, P.A. may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Patients **NOT** submitting insurance are responsible for payments of services rendered at the time of service.

_____

Signature of Patient/Guardian

_____

Printed Name

_____

Relationship to Patient

Accident Information

Is this visit related to a **RECENT** accident? ○YES ○NO

Date of Accident: _____

Type of Accident: ○Auto ○Slip and Fall

Have you seen anyone else for this?: ○YES ○NO

If YES, please list: _____

Patient Condition

Please choose any of the following condition(s) that you CURRENTLY have or have PREVIOUSLY had:

AIDS/HIV	Bleeding Disorder	Fracture	High Blood Pressure	Osteoporosis	Rheumatoid Arthritis
Alcoholism	Breast Lump	Goiter	High Cholesterol	Pacemaker	Stroke
Allergies	Bulging Disc	Gout	Kidney Disease	Parkinson's Disease	Suicide Attempt
Anemia	Cancer	Heart Disease	Liver Disease	Pinched Nerve	Thyroid Problem
Angina	Diabetes	Hepatitis	Migraine Headache	Polio	Tuberculosis
Appendicitis	Eating Disorder	Hernia	Miscarriage	Prostate Problem	Tumors
Arthritis	Emphysema	Herniated Disc	Multiple Sclerosis	Prosthesis	Ulcers Asthma
Asthma	Epilepsy	Herpes	Neuropathy	Psychiatric Care	Electronic Devices

Habits: Smoking - packs/day_____Alcohol _____Coffee/Caffeine _____

Occupation: _____
Full Time **Part Time**

Allergies: (medication, latex, etc)_____

Pregnant: YES NO **Due Date:**_____

Work Activity: Sitting Standing Light labor Heavy labor

Injuries/Surgeries: In the last 5 years have you had any surgeries, hospitalizations, fractures, motor vehicle collisions, falls or any other MAJOR trauma? _____
_____
_____
_____

Have you ever had any spinal (neck, mid back, low back) surgeries? If yes, when? Do you have any: pins, screws, rods, fusions?
_____
_____
_____
_____

List all current medications:
_____
_____
_____
_____

Family History

Is there a family history of any of the following condition(s)? If YES, please choose the relationship

(M = mother, F = father, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather)

Cancer*:** M F MGM MGF PGM PGF ***High Blood Pressure: M F MGM MGF PGM PGF ***Diabetes*:** M F MGM MGF PGM PGF

***Depression*:** M F MGM MGF PGM PGF ***Stroke*:** M F MGM MGF PGM PGF ***Alzheimer's Disease*:** M F MGM MGF PGM PGF

***Osteoporosis*:** M F MGM MGF PGM PGF ***Coronary Artery Disease*:** M F MGM MGF PGM PGF

FOR OFFICE USE ONLY

VITALS

HT:_____

WT:_____

PULSE:_____

BP:_____**R / L**

Fields Chiropractic
3930 Devine Street ● Columbia SC ● 29205
Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-ray, on me (or the patient named below, for whom I am legally responsible for) by the doctor of chiropractic named above or licensed doctors of chiropractic at **Fields Chiropractic Clinic, P.A.**

I have had an opportunity to discuss with the doctor, or with office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a medical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at any time to be in my best interest. Neither the practice of the chiropractor or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and the expertise in working with like cases.

I understand that as a part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party can verify that services billed were actually provided.

I have read or have had it read to me, the ***Informed Consent to Chiropractic Adjustments and Care.*** I have also had the opportunity to ask question about this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Please Print) Date Signed

_____

Signature of Patient or Legal Guardian

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, or direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physicians certification.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by my restrictions.

_____ _____

Patient Name (Please Print) Relationship to Patient

_____ _____

Signature Date

Designated Party Release

You may give Fields Chiropractic Clinic written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, etc.) on your home answering machine, voice mail at work, cell phone, email, or another party that you designate.

Patient Name: _____ **Date of Birth:**_____

At my request, I authorize Fields Chiropractic Clinic to disclose my protected health information to:

For Motor Vehicle Accidents, please list your attorney's name and phone number

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

At my request, I also authorize Fields Chiropractic Clinic to communicate my protected health information to me via the following methods:

- ○ Leave detailed message on my home answering machine (phone #:_____)
- ○ Leave detailed message on my voice mail at work (phone #:_____)
- ○ Leave detailed message on my cell phone voice mail (phone #_____)
- ○ Fax detailed medical information (fax #_____)
- ○ E-mail detailed medical information (email:_____)

Authorized Signature: _____Date:_____

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

Fields
CHIROPRACTIC
www.fieldschiro.com

Fields Health Clinic

3930 Devine Street • Columbia, SC • 29205
p.803.787.7050 f.803.787.0502

Notification of Outside Treatment

Fields Health Clinic has the unique opportunity to provide its patients with a variety of treatment options in one convenient location. Treatments include chiropractic manipulation, moist heat, electric muscle stimulation, flexion/distraction, ultrasound therapy, and decompression therapy when appropriate. Additionally, for any medical needs, an appointment with one of our nurse practitioners can be scheduled to review emergency department records, prescribe medications, and provide follow up care to include trigger point injections, steroid injections, or referrals to outside facilities when appropriate.

Because of this unique opportunity, we kindly ask for notification from the patient, and/or attorney before seeking or beginning other treatments. This is to prevent any duplication of services and for better continuity of care.

By signing below, _____ acknowledges receipt of this notification and agrees to communicate with Fields Health Clinic staff any outside appointments related to any personal injury claim.

_____
Patient Signature

_____
Date

Fields Health Clinic, LLC

Dr. James M. Fields Dr. Andrew J. Fields Dr. Chapin Jennings Dr. David Koentop
3930 Devine Street, Columbia SC 29205 Phone (803) 787-7050 Fax (803)787-0502
www.fieldschiro.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the below health care facility/physician to release my health information to **FIELDS HEALTH CLINIC, P.A.,** including the treatment/testing for psychiatric problems, sexual assault, drug abuse and/or alcoholism, sickle cell anemia, and/or Acquired Immunodeficiency Syndrome (AIDS), or testing for infection with HIV.

****Please be advised that any imaging requested will be charged a fee of $25.00****

Patient Name:_____

Birthdate:_____

Persons/organizations providing the information:_____

Persons/organizations receiving the information:

Fields Health Clinic, P.A. ***PLEASE FAX RECORDS TO: 803-787-0502***

Information Requested:

☐ Imaging Reports ☐ Other:_____

☐ Emergency Department Summary

☐ All Records Date:_____

_____ _____

Signature of patient/patient's representative Date

Confidential Information

This facsimile contains information that is confidential and/or legally privileged. The information is intended only for the use of the individual or entity named on this transmission sheet and my not be disseminated to any other party without permission. If you are not the intended recipient or the employee/agent responsible for delivering the message to the intended recipient you are hereby notified that nay dissemination, disclosure, distribution copying or taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone at 803-787-7050 to arrange for the return of these documents without cost to you.