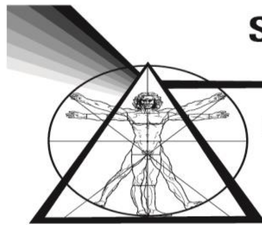


**Sheen Family Chiropractic**
**Dr. James D. Sheen, P.C.**

203 W 32nd St.
Kearney, NE 68845
308.236.2134

118 E 6th St., Ste. 2
Lexington, NE 68850
308.324.3224

**PATIENT HEALTH INFORMATION** [HIPPA ACKNOWLEDGEMENT] **CONSENT FORM**

We want you to know how your Patient Health Information (PHI) is going to be used in this office & your rights concerning those records. Before we will begin any health care operations, we must require you to read & sign this consent form stating that you agree with how your records will be used. If you would like to have a more detailed account of our policies/procedures concerning the privacy of your Patient Health Information, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk prior to signing this consent.

1. The patient understands & agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations & coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us, by the patient, for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine & obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made & submit in writing, any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security & right to privacy, all staff has been trained in the area of patient record privacy in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment & health care operations, our office reserves the right to refuse to give care.

I agree to allow the following person(s) to have access to my file &/or health information & records:

______________________________________________

______________________________________________

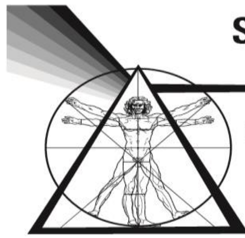
______________________________________________

______________________________________________

I have read & understand how my Patient Health Information will be used & I agree to these policies/procedures.

______________________________________________
Printed Name of Patient

______________________________________________
Signature (Guardian signature required for minors) Date



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**IN OFFICE USE ONLY**
**Account #:** ________________

**Patient Ht:** ________________

**Patient Wt:** ________________

**Patient BMI:** ________________

**Patient BP:** ________________

## Patient Information

Title: Mr. / Mrs. / Ms. / Dr. / Rev. / Rank _______

Last Name ____________________________ First Name ____________________________ MI ________

Address ______________________________________ City _________________ State ______ ZIP_____________

Home Phone # _________________________________ Mobile Phone # __________________________________

Work Phone # __________________________________ E-Mail _______________________________________

Employer Name _________________________________________ Occupation ____________________________

Age _______ Date of Birth _________________ Gender: Male Female

Social Security # _______________________________ Are you a student? Yes No

Marital Status: ____ Single ___ Married ____ Widowed ____ Separated ____ Divorced

Spouse Name __________________ Employer _______________________ Phone # ________________

Children (Name/Age): ____________________________________________________________________

Emergency Contact Name __________________________________________ Relationship _________________

Home Phone # __________________ Mobile Phone # ____________________ Work Phone # ____________________

Primary Care Physician: _________________________________________ Last visit: _________________________

Race (circle 1): White Hispanic or Latino Asian African American Native American

Preferred language: ____ English ____ Spanish ____ French ____Other

Tobacco Use: ____ Never ____ Former smoker ____ Current Everyday ____ Current Some Days

Alcohol Use: ____ Never ____ Daily ____ Socially/weekends ____ Occasionally ____ Infrequently

Most patients are referred to our office by a caring friend/family member. What made you decide to make an appointment with Dr. Sheen? □ Family/Friend [Name____________________________] □ Advertisement □ Other ____________

Have you ever been under chiropractic care? ____ Yes ____ No If Yes, Doctors name: ___________________________

## Health Insurance and Financial Policies

Do you currently have health insurance? ____ Yes ____ No If yes, what company? ___________________________

1. We are currently providers for Blue Cross Blue Shield, Midlands Choice, & Medicare and will submit your insurance.

2. If we are not a provider for your insurance, we would be happy to print a receipt or claim form for you to send in.

3. Please fill out Insurance Questionnaire included in paper work and provide the front desk with your insurance card so we may make a copy & place it in your file.

Our fees are considered usual, customary, and reasonable amongst most companies; therefore, are covered up to the maximum allowance determined by each carrier. Please note that Low Level Light Therapy (LLLT) is not covered by most insurance companies & charges for LLLT will be your responsibility.

***If your visit is ever the result of an Auto Accident, Workers Compensation, or Personal Injury please notify staff immediately so proper paperwork can be completed. If any claims are denied or not paid by the insurance company, the bill will be your responsibility.**

Is this condition due to a car accident? ___ Yes ___ No Date: ___________

Is condition due to a work related injury? ___ Yes ___ No Date: __________ Reported to supervisor? ____ Yes ____ No

- If you do not have insurance, **ALL** payments are expected at the time of service
- If you have insurance, **ALL COPAYS & CO-INSURANCE** are due at the time of service
    - If deductible is not met or in question, we will be collecting for each visit
    - By taking care of this while you are in the office, it minimizes the need for an invoice
- There will a $25.00 charge on all returned checks
- If you need additional documentation other than a receipt, please feel free to ask the front desk as we are able to provide that you at no additional charge.
- If you discontinue care for any reason other than discharge by doctor, all balances will become immediately due & payable in full.

## Health History

What are your chief complaints and symptoms? ______________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Females: Is there a possibility you are pregnant? ___ Yes ___ No If yes, approximate due date: _______________

If in pain is your pain/discomfort constant? ___ Yes ___ No Intermittent? ___ Yes ___ No

How would you describe pain/discomfort? (please circle all that apply) Sharp/Stabbing Dull Achy Cramping Soreness

Please rate your pain at its worst on a scale from 0-10, with "10 being worst and "0" being no pain at all.

0 1 2 3 4 5 6 7 8 9 10

Please list anything that makes pain worse? _________________________________________________________________

Please list anything that relieves or eases pain? ______________________________________________________________

When did you first notice the pain/discomfort? ___Within 3 days ___ 4-7 days ___ 1-3 weeks ago ___ 1-3 months

___ 4-6 months ago ___ 6-9 months ago Other ___________________________________________________________

Please mark with an (x) any of the following that apply to you:

| | | | |
|---|---|---|---|
| _____ Headaches | _____Wrist/Hand Pain | _____ Low Back Pain | _____ Upper Back Pain |
| _____ Mid Back Pain | _____ Hip Pain | _____ Knee Pain | _____ Chest Pain |
| _____ Fibromyalgia | _____ Muscle Spasms/Cramps | _____ Gall Bladder Problems | _____ Shoulder Pain |
| _____ Visual Problems | _____ Asthma | _____ Acid Reflux/Indigestion | _____ Digestive Problems |
| _____ Allergies/Sinus | _____ Ringing in Ears | _____ Urinary Tract Problems | _____ High Cholesterol |
| _____ High Blood Pressure | _____ Anemia | _____ Menstrual Issues | _____ Thyroid Problems |
| _____ Neck Pain/Stiffness | _____ Loss of taste or smell | _____ Dizziness | _____ Numbness or tingling |

## Genetic History

Have you or any of your immediate family had any of the following? If yes, please list Mother, Father, Brother, or Sister.

Heart Disease_____________________________________ Stroke ________________________________________

Cancer __________________________________________ Arthritis ______________________________________

Diabetes ________________________________________Auto-Immune Disease __________________________

High Blood Pressure ___________________________

## Hospitalization, Surgeries & Injuries

Do you have a pacemaker (or defibrillator)? ____ Yes ____ No

Have you ever had neck/back surgery? ____ Yes ____ No If yes, please list below.

Have you ever had a knee/hip replacement surgery? ____ Yes ____ No If yes, please list below.

Please list any hospitalizations, surgeries, significant injuries & broken bones that you have had (*if none, write NONE*):

1. Description ____________________________________________________ Date: ___________________
2. Description ____________________________________________________ Date: ___________________
3. Description ____________________________________________________ Date: ___________________
4. Description ____________________________________________________ Date:___________________

## Medications and Supplements

Please list any medications, supplements or over-the-counter drugs that you are currently taking with dosage/day. You may also provide a copy to the staff.

1. ____________________________________________ 4. ____________________________________________
2. ____________________________________________ 5. ____________________________________________
3. ____________________________________________ 6. ____________________________________________

Do you have any allergies to medications? ___ Yes ___ No If yes to what?____________________

## Acceptance as Patient & Signature on File

I certify that all of the information provided is correct & accurate. I also understand & agree that Dr. James D. Sheen P.C. has the right to refuse treatment at any time. I authorize the release of all medical information to my insurance carrier and authorize Dr. James D. Sheen P.C. to assist me in obtaining payment from such companies. I also authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

Sheen Family Chiropractic is a very busy clinic & when an appointment is scheduled, we reserve that time for you only. There will not be a fee for rescheduling or canceling an adjustment. However, please call as soon as possible to notify us when you need to cancel or reschedule so that we may accommodate other patients that need an appointment.

_________________________________________________________ ___________________________

Patient (or Guardian) Signature Date