CRAWFORD CHIROPRACTIC

King Chiropractic Clinic, PC
John D. Crawford, D.C.

PERSONAL HISTORY

DATE: ______________________ Social Security: ______________________________

Name: ____ DOB: ____________________

Address (Street): ____

Address: (City, ST, and ZIP): ____

Phone: (______) ________ - __________ Choose One: Verizon, Sprint, AT&T, Other ___________

Employer: __________________________ Occupation: ________________________________

Circle if you are: Married Single Widowed Divorced Separated Student

Name & Telephone Number of person to contact in case of emergency:

____

Referred to this office by: ____

Is this related to: AUTO ACCIDENT: (   ) YES (   ) NO
WORKER'S COMPENSATION: (   ) YES (   ) NO

Have you seen another Chiropractor or Medical Physician within the last 12 months?
(   ) YES (   ) NO If so, when? ____
Specify doctor and clinic name: ____

Have you had any X-Rays or other Radiographic Imaging Studies done in the last 12 months?
(   ) YES (   ) NO If so, specify: ____

Do you have any of the following?
(   ) TUMORS (   ) BLEEDING DISORDERS (   ) DIABETES (   ) PACEMAKER
(   ) ELECTRONIC IMPLANTS (   ) BLOOD PRESSURE PROBLEMS (   ) HEART PROBLEMS
If so, explain: ____

____

List all previous surgeries: ____

____

FEMALE PATIENTS ONLY: Are you pregnant? (   ) YES (   ) NO INITIALS: ______

FRONT PAGE – TURN PAGE OVER

BACK PAGE – CONTINUED FROM FRONT

PRESENT COMPLAINT: ____

____

____

How did it start? ____

When did it start? ____

What makes the problem better? ____

What makes the problem worse? ____

My pain level is 0 -10 (0- none at all and 10- worst pain you've ever been in):

0 1 2 3 4 5 6 7 9 10

My pain frequency is (choose one): 25-50% 50-75% 75-100% of time

My pain is getting ( ) WORSE ( ) BETTER ( ) SAME

My pain is ( ) SHARP ( ) DULL ( ) STABBING ( ) THROBBING ( ) SHOOTING

Along with my major complaint, I also periodically have:

( ) HEADACHES ( ) NECK PAIN ( ) MID BACK PAIN ( ) LOW BACK PAIN

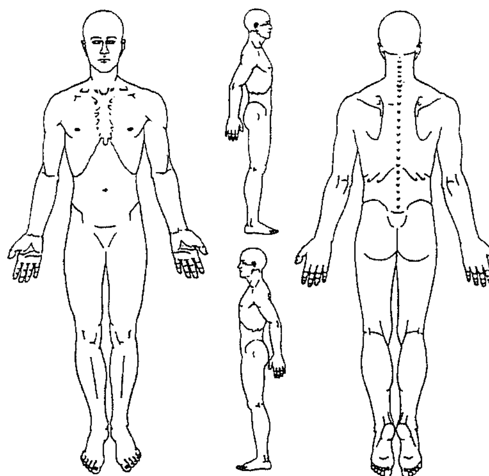
( ) PAIN, NUMBNESS OR TINGLING IN MY ARMS OR LEGS

Indicate ability to perform the following activities:

(USE CODES: U-Unable P-Painful D-Difficult L-Limited)

____Coughing or Sneezing
____Getting in or out of bed
____Bending forward to brush teeth
____Turning over in bed
____Walking short distance
____Standing for more than 1 hour
____Sitting at a table
____Lying on back
____Lying on stomach
____Lying on side with knees bent
____Bending over forward
____Climbing
____Kneeling
____Balancing
____Dressing self
____Sleeping
____Stooping
____Gripping
____Pushing
____Pulling
____Reaching
____Sexual activity

SHADE AREA(S) TO INDICATE LOCATION OF PAIN OR DISCOMFORT:



List all medication you are taking & for what condition: ____

____

List all major accidents or injuries: ____

____

I have filled out this form to completion and everything is accurate and true to the best of my knowledge, signed: ____

(Patient Signature)

CRAWFORD CHIROPRACTIC

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John D. Crawford, D.C.

PATIENT NAME: ________________________________ **DATE OF BIRTH:**______________

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

________________________________ ________________________________

Signature of Patient or Personal Representative **Date**

________________________________ ________________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**

________________________________ ________________________________

Signature of Witness **Date**

CRAWFORD CHIROPRACTIC

King Chiropractic Clinic, PC

John D. Crawford, D.C.

Payment Policy

Welcome! Thank you for selecting us as your chiropractic health care provider. Our goal is to provide you and your family with optimal care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.
Financial Agreement:

Patients are expected to pay for our services at the time they are rendered. Patients who have health insurance are expected to pay the amount of their estimated co-pay and/or deductible/co-insurance at the time of service. Payments may be made using cash, check, or card (Visa, MasterCard, Discover and/or American Express with a 4% processing fee).

We offer payments plans as well which can be discussed with the office manager and a credit card or blank check must be provided for automatic payments. Accounts are considered past due if no payment has been received within 30 days from last date of service and are subject to a 1.5% monthly finance charge. Delinquent accounts will be sent to a collection agency that reports to major credit bureaus after we have exhausted all attempts to collect the balance with all applicable fees added to the account balance.

We accept Auto Accident/ Worker's compensation cases and you are required to complete a lien. You are ultimately responsible for payment for services rendered. Worker's Compensation cases must be pre-approved through your employer before starting treatment.

_______________________________________ _______________

Patient or Personal Representative Signature Date

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing, you are consenting to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations by Dr. Crawford and his staff at Crawford Chiropractic (King Chiropractic Clinic, PC). You also give consent for any other medical records to be released to this office from any other facility upon request.

Notice of Privacy Policy: Our Notice of Privacy Policy provides a description of the uses and disclosures we make of your health information. You have the right to read this notice before you decide to sign this consent. You have the right to obtain a copy of our Notice or Privacy Policy at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us a written notice submitted to the Contact Person listed below. This revocation does not affect any action we took in reliance on this consent before we received your revocation and we may decline any further treatment if you revoke this consent.

Patient/Doctor Communication: By signing this consent, you give the right for Dr. Crawford and his staff to contact you via text, email, phone call or mail regarding your treatment, account and other communication.

_______________________________________ _______________

Patient or Personal Representative Signature Date

You may obtain a copy of our Notice or Privacy Practices Policy, including any revisions, and this consent at any time by contacting Brittney Jackson, RN – (706)891-1011 or crawfordchiro97@gmail.com