ACE Family Chiropractic

14311 Reese Blvd. West, #A1
Huntersville, NC 28078
704-727-0784 • 888-758-9829 (FAX)
info@AceFamilyChiropractic.com

Patient Entrance Data

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health issues and deliver the best possible treatment.

First Name _____ Last Name _____
Address _____ Birthdate _____ Sex ☐M ☐F
City _____ State _____ Zip _____
Home / Cell Phone _____ Work Phone _____
Soc. Sec. # _____ E-mail _____
Health Insurance _____ May we E-mail you? ☐Yes ☐No
Subscriber ID _____ Marital Status ☐S ☐M ☐D ☐W ☐Other
Group # _____ Employer _____
Emergency Contact _____ Occupation _____
Relationship _____ Emergency Phone _____

Who is responsible for your bill? ☐Self ☐Health Insurance ☐Medicare ☐Auto Insurance ☐Other
If "Other" specify: _____

Accident Questionnaire

Briefly describe the accident:

_____

_____

_____

Were you at-fault? ☐ Yes ☐ No **Accident Date:** _____ **State:** _____
Your vehicle was a: ☐ Car ☐ Mini-Van ☐Truck ☐ Other _____
The other vehicle was a: ☐ Car ☐ Mini-Van ☐Truck ☐ Other _____
Were you the: ☐ Driver ☐ Passenger If Passenger, where seated? _____

Were you at a complete stop? ☐ Yes ☐ No
If no, were you slowing down? ☐ Yes ☐ No Approx. speed was _____ mph
If no, were you speeding up? ☐ Yes ☐ No Approx. speed was _____ mph
Where was your head turned during impact? ☐ Forward ☐ Turned Left ☐ Turned Right
Were you aware of the pending impact? ☐ Yes ☐ No
Were you wearing a seatbelt? ☐ Yes ☐ No
Did an airbag deploy? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
Did you hit anything in the car? ☐ Yes ☐ No What hit where? _____
Did you sustain ☐ cuts ☐ bruises? ☐ Yes ☐ No If yes, where? _____

What was the height of the headrest? ☐ Base of Head ☐ Mid Head ☐ Top of Head ☐ No Headrest

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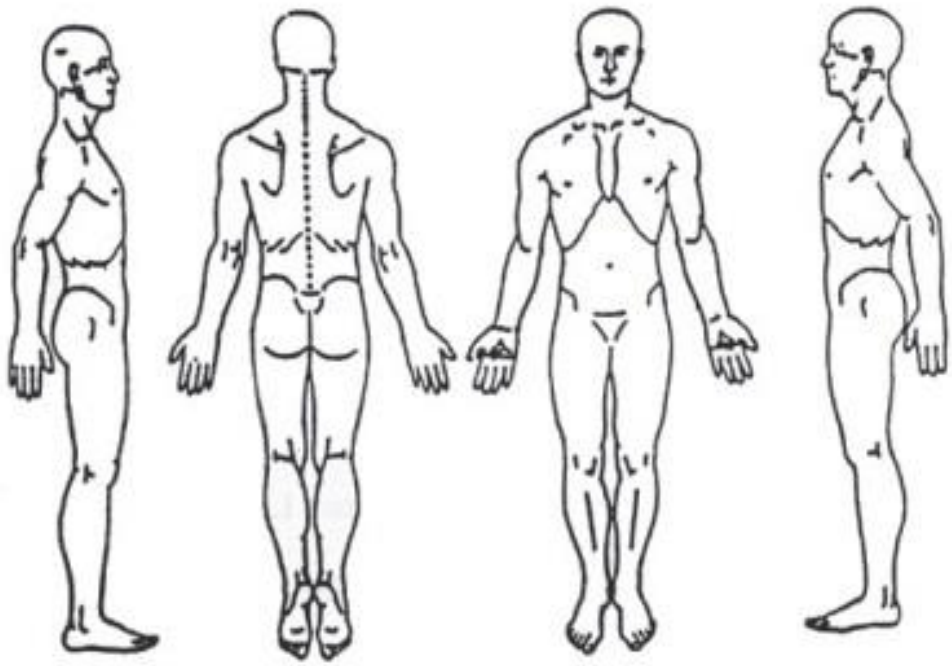
Current Symptoms

Please "X" on the area(s) where you have discomfort and draw lines to where it radiates.



Describe your symptoms (i.e. sharp, dull numbing, shooting, burning, tingling, stabbing, radiating, etc.)

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

What is your primary complaint? _____

When did your symptoms begin? _____

What do you think was the cause? _____

Are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

What makes it better? _____

What makes it worse? _____

How frequent are your symptoms? ☐ 76%-100% of the time ☐51%-75% of the time ☐26%-50% of the time ☐ 0%-25% of the time

How long does each episode last? _____

Rate the severity of your symptoms from 1 – 10 (10 being the worst) _____

Does this interfere with your daily life? ☐ Not at all ☐A bit ☐Moderately ☐Quite a bit ☐Extremely

In general, would you say your overall health right now is: ☐Excellent ☐Very Good ☐Good ☐Fair ☐ Poor

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Other Treatment Information

Did you go to the Emergency Room? ☐ Yes ☐ No If Yes, when? _____
If yes, how did you get there? ☐ Drove Self ☐ Ambulance ☐ Friend / Family
Treatments received: ☐ CT ☐ MRI ☐X-ray ☐ Back Brace ☐ Neck Brace
☐ Other _____

List all doctors that you have seen as a result of your injuries (other than the ER):

	Date	Doctor	Treatment
1.			
2.			
3.			

Do you have any future appointments with any doctor regarding your injuries? ☐ Yes ☐ No
If Yes, when and with whom? _____

Personal Health History

	Yes	No	If yes, explain briefly
Are you pregnant?	☐	☐	
Do you smoke?	☐	☐	
Have you ever. . .	☐	☐	
. . . had cancer?	☐	☐	
. . . had a surgery?	☐	☐	
. . . had a broken bone?	☐	☐	
. . .been in a car accident?	☐	☐	

Family Health History

If any blood relative has any of the following, check and indicate which relative(s).

□ Alcoholism	□ Bleed easily	□ Epilepsy	□ High cholesterol
□ Anemia	□ Cancer	□ Glaucoma	□ Multiple sclerosis
□ Arthritis	□ Diabetes	□ Heart disease	□ Osteoporosis
□ Asthma	□ Emphysema	□ High blood pressure	□ Stroke
			□ Thyroid disease

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Insurance / Attorney Contact

Insurance responsible for payment is. . . ☐ MY INSURANCE ☐ OTHER DRIVER'S INSURANCE

Insurance Company _____

Adjustor's Name _____ E-mail _____

Adjuster's Phone _____ Fax _____

Address _____

Insurance Claim # _____

Do you have an attorney? ☐ YES ☐ NO

Attorney Office _____

Attorney Name _____

Contact Person _____

Contact Phone _____ Fax _____

Address _____

Thank you for completing this intake form. Information contained within this form is confidential and your honest responses are critical to helping us deliver the best possible treatment.

_____ _____ _____

Patient Signature | Print Patient Name | Date

CONSENT TO TREAT A MINOR *(IF PATIENT IS A MINOR)*

I hereby request and authorize Dr. Teng Xiong and whomever he may designate as his assistant or authorized representative to administer chiropractic care as he deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

As of today's date, I have the legal right to select and authorize healthcare service for the minor child named below. I will notify this office in writing immediately should I wish to terminate this consent.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

Child's Name | Your Relationship to Child

_____ _____ _____

Parent / Guardian Signature | Print Parent / Guardian Name | Date

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ASSIGNMENT OF BENEFITS

This is an agreement between Ace Family Chiropractic and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Ace Family Chiropractic.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in effect. You may receive a copy of this agreement upon request.

Charges to Account: Upon reaching an agreement with your insurance company or attorney, charges may be made to your account without payment at time of service during your personal injury claim. We shall have the right to cancel this privilege at any time if circumstances between this office and your attorney or insurance company change. When appointments are not made and kept according to your treatment plan, you may be released from our care due to non-compliance. Treatment may no longer be charged to your account. The bill from your personal injury treatment may or may not be transferred to you.

Insurance and Payments: While you are under care for your personal injury you authorize us to send your records and bills to the appropriate companies (i.e. auto insurance company or attorney). You authorize your insurance company(s) or attorney to pay benefits directly to Ace Family Chiropractic. If benefits are paid directly to you the patient, payment for your full bill will be expected promptly after your settlement is reached.

You remain personally liable for the total amount due to Ace Family Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. Any unpaid balance over 120 days post settlement will be transferred to our collections agency. If Ace Family Chiropractic is required to take legal action against you to recover any unpaid balance on your account, you agree to reimburse Ace Family Chiropractic for its costs of recovery, including any reasonable attorney fees.

Statements: During your treatment all bills and records will be sent directly to the appropriate sources. Please inform the office manager if you would like a copy of your settlement mailed to your home address each month. In the case that a settlement is reached and paid directly to you, you will receive a final bill detailing all charges. It will show previous balances, new charges and any payments or credits applied to your account during the previous months. Prompt payment is expected for the total charges.

Patient / Guardian Signature	Print Name	Date

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Ace Family Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Ace Family Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44 – 50.1. Ace Family Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

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CONSENT OF TREATMENT

Healthcare providers are required to advise patients of the nature of treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective in the treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. ***Musculoskeletal care contributes to your overall wellbeing. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address and nature of the treatment.
b. The risks and benefits of that treatment.
c. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Ace Family Chiropractic.

_____	_____	_____
Signature (Patient / Guardian)	Print Name	Date

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Consent for Purposes of Treatment, Payment, & Healthcare Operations

I understand and have been provided with a copy of Ace Family Chiropractic's Notice of Privacy Practices, which provides a more complete description on the uses and disclosure of my health history. I understand that I have the right to review the notice prior to signing this consent. I understand that Ace Family Chiropractic has the right to change this notice of practice prior to implementation and will mail a copy of any revised notice to the address I've provided.

By signing below I give my consent for Ace Family Chiropractic to disclose my record for treatment, payment, and healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that Ace Family Chiropractic has already taken action in reliance thereon.

I provide Ace Family Chiropractic with my authorization and consent to use my protected healthcare information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

_____	_____	_____
Signature (Patient / Guardian)	Print Name	Date

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NOTICE OF PRIVACY PRACTICES

ACE Family Chiropractic is required by law and in compliance with HIPPA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

There are a number of situation in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and healthcare operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, or healthcare operations requires you to sign an Authorization.

You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to such restrictions. Certain disclosures required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so.

Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

As a courtesy, we may call your home or leave a message, stating your next appointment date and time or missed appointments. We may call your work and leave a message to return our call. No personal health information will be disclosed.