

Graybar Chiropractic & Rehab Centers
Confidential Health Record

Wallace 116 N. Norwood Street
Wilmington 2110 S. 17th Street
Clinton 600 Beaman Street

How did you hear about us? Radio Television Yellow pages Office Sign Insurance Plan
Family _____ Friend _____ Prior patient Newspaper
Co-Worker _____ Dr. _____ Billboard _____

Personal Information

Today's Date:

First: _____ Middle: _____ Last: _____ Sex: Male / Female
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone : (____) _____ - _____ Cell Phone: (____) _____ - _____ Cell Carrier _____
Status: Single Married Divorced Widowed Separated Birth Date: ____ / ____ / ____ Age: ____
Social Security #: _____ - _____ - _____ Fax #: (____) _____ - _____
Driver's License #: _____ State: _____ Email Address: _____
Spouse Name: _____ Children (Names and Ages): _____

Emergency Contact

Name: _____ Phone Number: (____) _____ - _____
Address: _____ Relationship: Spouse Relative Friend Other _____

Employment Information – Job description

RETIRED DISABLED UNEMPLOYED

Business Name: _____ Occupation/Job Title: _____
Business Address: _____ Name of Supervisor: _____
Business Phone: (____) _____ - _____ Type of Work: _____ Work: ____ hrs/day or ____ per week
Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)
Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Insurance Information:

Who is responsible for your bill? YOU and... (Mark appropriate box(es)) Myself ONLY Spouse
 Worker's Comp Auto Insurance Medpay claim Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID card #: _____
Policy Holder's Name: _____ Group #: _____
Policy Holder's Social Security #: _____ - _____ - _____ Policy Holder's Birthday Date: _____
Primary Care Physician: _____ Carolina Access Number: _____

Workers Compensation Injury / Auto / Personal Injury

Have you filed an injury report Yes No

Carrier: _____ Policy # _____
Carriers Phone #: (____) _____ - _____ Adjuster: _____
Claim #: _____ Date: ____ / ____ / ____ Time: _____ am/pm

Current Health Conditions

Pain

Numbness

Stiffness

Weakness

Symptoms causing patient to seek treatment: _____

When did this problem begin (Actual Date)? _____

Has it ever occurred before? Yes No When? _____

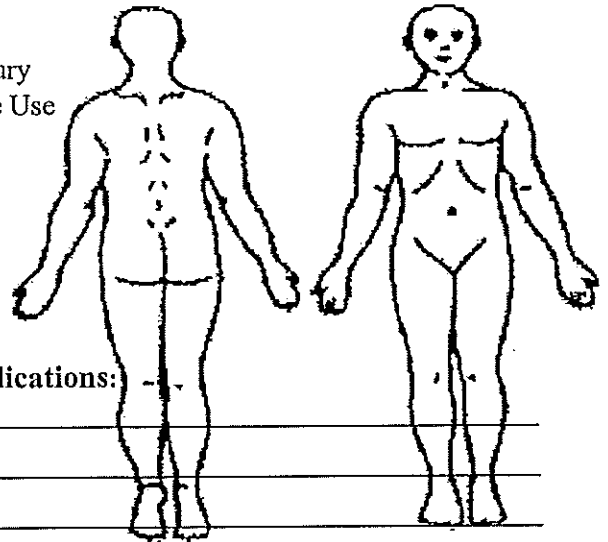
Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing

PLEASE LABEL THE AREA OF DISCOMFORT

Cause of injury: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Overexertion Repetitive Use
 Other

Explain: _____



Prior treatment for this condition (other doctors), including medications:

If yes, who? When? (Name) Type of Treatments: _____

Explain: _____

Location and radiation of symptoms: Left / Right / Bilateral _____

Quality of Pain: Burning Stabbing Diffuse Throbbing Dull/Aching Tightness Localized Tingling Radiating Other Sharp Shooting

Severity of Pain:(With Activity) 10 - worst 0 1 2 3 4 5 6 7 8 9 10

Duration of symptoms: ___ day(s) ___ week(s) ___ month(s) ___ year(s) other _____

Frequency of symptoms occurring: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Intensity: Mild Mild/Moderate Moderate Moderate/Severe Severe

Timing: Better: Morning Afternoon Night
 Worse: Morning Afternoon Night

Symptoms Better With: nothing helps massage stretching activity movement sitting bending OTC meds standing applying cold Rx meds twisting applying heat rest walking

Symptoms Worse With: nothing helps massage stretching activity movement sitting bending OTC meds standing applying cold Rx meds twisting applying heat rest walking

Secondary Complaints (Other Associated Signs and/or Symptoms)

- | | | | | |
|-----------------|-----------------|-------------------------|----------------------|-------------|
| headaches | burning | cold limb(s) | difficulty breathing | dizziness |
| joint stiffness | aches | blurred (double) vision | fatigue | heartburn |
| muscle spasm | ringing in ears | nausea (vomiting) | sleep disturbance | fever |
| muscle weakness | pins & needles | chest pain | difficulty walking | sweating |
| swelling | tingling | shortness of breath | depression | mood swings |

PAST HEALTH HISTORY

Previous Chiropractic Care: Previous chiropractic care No previous chiropractic care

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Social History: Mark all that apply below.

Tobacco: Do not use Tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
 Smoke: # _____ per Day Week Month; Chew: # _____ cans per Day Week Year

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury broken bones fall (severe) fracture
 disability (ies) head injury loss of consciousness joint injury
 laceration (severe) motor vehicle accident soft tissue injury other:

Females ONLY: Mark all that apply below.

I AM: currently pregnant NOT pregnant unsure

Past Pregnancy History: C-section vaginal delivery miscarriage

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood or Adult Illness (es): LIST all health conditions (past or present).

Work Activities: Condition's (Chief Complaint) Effect On Job Performance:

Mild Painful (Can do) Mod Painful (limited ability) Mod/Sev Limited Duty Sev No Limited Duty Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Sleep:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Walking:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Constant Sitting:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Constant Standing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Change Posn-Sit-Stand:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Turning the Head:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Climb Stairs:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Driving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Self Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Bending:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Rendering Child Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lifting (at work):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

Lifting (at home):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Lifting (overhead):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Caring for Family:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Carrying Groceries:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Extended Computer Use:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Reading (Concentration):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Studying (homework):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Household Chores:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Pet Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Playing (kids)	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
PE (gym class activities):	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform
Yard Work:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Sev Unable to Perform

List Any Recreational Activities which are restricted due to this condition

Favorite Sport _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
 Favorite Hobby _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as the problems can affect your overall course of care. *Mark the box, (I DENY), if you do not have any of these symptoms otherwise mark the appropriate boxes that relate to your history.*

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills daytime drowsiness fatigue fever night sweats
 weight gain weight loss other:

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- blindness blurred vision cataracts change in vision double vision
 eye pain field cuts glaucoma itching photophobia
 tearing glasses contact lenses other:

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- bleeding dentures difficulty swallowing discharge dizziness
 ear drainage ear pain fainting frequent sore throats headaches
 hearing loss history of head injury hoarseness loss of sense of smell nasal congestion
 nosebleeds postnasal drip rhinorrhea (runny nose) sinus infections snoring
 sore throat tinnitus (ringing in ears) TMJ problems other:

Respiration: I DENY having any of the symptoms or problems listed below.

- asthma cough coughing up blood shortness of breath sputum production
 wheezing other:

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort) chest pain claudication (leg pain/ache)
 heart murmur heart problems high blood pressure
 low blood pressure orthopnea (difficulty breathing lying down) palpitations
 paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) shortness of breath with exertion or exercise swelling of legs
 ulcers varicose veins other:

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- abdominal pain belching black - tarry stools constipation diarrhea
 difficulty swallowing heartburn hemorrhoids indigestion jaundice
 nausea rectal bleeding abnormal stool caliber abnormal stool color abnormal stool consistency
 vomiting vomiting blood other:

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control breast lumps/pain burning urination cramps frequent urination
 hormone therapy irregular menstruation pregnancy urine retention vaginal bleeding

Male: I DENY having any of the symptoms or problems listed below.

- burning urination erectile dysfunction frequent urination hesitancy dribbling

Endocrine: I DENY having any of the symptoms or problems listed below.

- cold intolerance diabetes excessive appetite excessive hunger excessive thirst
 abnormal frequency of urination goiter hair loss heat intolerance unusual hair growth
 voice changes other:

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture changes in skin color hair growth hair loss hives
 history of skin disorders itching paresthesias rash skin lesions / ulcers
 varicosities other:

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness facial weakness headache limb weakness loss of consciousness
 loss of memory numbness seizures sleep disturbance slurred speech
 stress strokes tremor unsteadiness of gait loss of balance

Psychological: I DENY having any of the symptoms or problems listed below.

- anhedonia anxiety loss or change in appetite behavioral change bi-polar disorder
 confusion convulsions depression insomnia memory loss
 mood change other:

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis food intolerance itching nasal congestion rash
 sneezing other:

Hematological: I DENY having any of the symptoms or problems listed below.

- anemia bleeding blood clotting blood transfusion bruising easily
 fatigue lymph node swelling other:

With my signature below, I certify that to the best of my knowledge everything is accurate within this historical review and these intake forms.

Patient's Signature: _____ **Physician's Signature:** _____

Office Policies and Procedures

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Graybar Chiropractic & Rehab Centers will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Graybar Chiropractic & Rehab Centers will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable. It is understood and agreed that the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Informed Consent for Chiropractic Care

Today's Date _____

I hereby authorize the Doctors to treat my condition, as he/she deem appropriate through the use of Graybar Chiropractic & Rehab Centers. I am aware that the practice of medicine and chiropractic is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment. I also understand that there are risks associates with all types of medical and chiropractic procedures. I am informed and understand the risks associated with chiropractic care (informed consent) and hereby consent to examination and treatment following consultation with the doctors. I acknowledge that the risks and benefits of chiropractic care were verbally reviewed with me.

Patient's Signature: _____ **Physician's Signature:** _____

Graybar Chiropractic & Rehabilitation Centers have created unique healthcare facilities dedicated to the non-surgical treatment of the acutely and chronically injured patients. Our clinics use the most advanced techniques available to increase patient's physical capacity and to help them return to daily activities, work and sports. Our centers offer comprehensive care inclusive of: chiropractic (Pro-Adjuster) care, massage and physical therapy/rehab as well as cervical and lumbar disc decompression (VAX-D Disc Decompression) in three convenient locations. This full spectrum of comprehensive injury treatment and rehabilitation using non-invasive (pain-free) methods is offered exclusively at our clinics.

I acknowledge that I have received the Graybar Chiropractic & Rehab Centers Notice of Privacy Practices for protected health information.

Patient Name: _____ **Patient's Signature:** _____ **Date:** _____

Graybar Chiropractic & Rehab Centers
Patient Authorization for Medical Information

Patient Name: _____ Social Security #: _____ Date of birth: _____

Release of Information:

By signing this form, you are granting consent to Graybar Chiropractic & Rehab Centers to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Your chiropractic staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with reminder and information.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Medicare and Medicaid Consent to Release Information:

I certify that the information given to me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

I hereby authorize the release of my health information: data shall include all records including x-rays and diagnostic findings.

From: Clinic Name: _____ To: Graybar Chiropractic & Rehab Centers
Address: _____ PO Box 15033
City, State, Zip Code _____ Wilmington, NC 28408 Fax: 910- _____

This consent shall be valid for: _____ (not to exceed one year). I certify that this authorization is made freely, voluntarily and without coercion. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. I understand that the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by State and Federal law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I have received a copy of this authorization for my records.

Signature required here for Medical release: _____ **Date:** _____

Consent for Treatment:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Signed: _____ Date: _____ Signed: _____ (guardian signature)
Treatment of a minor requires guardian or parent signature

Witness: _____ Date: _____
MEDICAL RECORDS USE ONLY

Date Received: _____ Initials _____ Date Sent/Faxed _____ Initials _____

*Form must be completed before patient, parent/guardian or personal representative signs.
Explain form to patient/personal representative. Give the patient a copy of this 'signed' authorization for their records. Return original to medical records for processing.*

HIPAA Notice of Privacy Practices

Graybar Chiropractic & Rehab Centers

116 Norwood St Wallace, NC 28466
910-285-7222

2110 South 17th Street Wilmington, NC 28409
910-343-5250

610 Beaman Street Clinton, NC 28328 910-596-2222

For Office Use Only:

Signature below is acknowledgement that you have received/reviewed our HIPAA Notice of our Privacy Practices.

Patient Name _____

Signature _____ Date _____

Representative Name: _____

Witness Signature _____ Date _____

We have built this practice on our reputation of patient satisfaction and trust. With this in mind, we would love the opportunity to share with your friends and family the care that we will extend to you in our offices.

Please check the boxes below which you feel comfortable with:

- Telling friends, family and/or other clients via phone or in person that you are at our office*
- Using of your name on a personal referral / reference board in our reception area*
- Using of your name in a testimonial reference manual*
- Allowing to send you a birthday card on your special day*
- Discussing your clinical success with other patients in the office*
- During your second week of care, we use a patient survey form that asks to use your name, with your permission, in a patient advertisement letter that gets sent only to your family and friends.*

- Please do not disclose any personal information, diagnosis and/or treatment with anyone except:*

Patient Signature _____

Date _____

Graybar Chiropractic & Rehab Centers

Patient Financial Responsibility Form – Medically Necessary vs. Clinically Appropriate

Dear Patient,

Because we are focused on your overall health and wellness, it is important to us that you understand the terms: “Medically Necessary” and “Clinically Appropriate.”

“Medically Necessary”: Is defined by your insurance carrier as treatment or service that is specific to your diagnosis and which your insurance company will pay for per your contract with them. The insurer only pays for chiropractic care that has a direct connection to documented improved function. There may be specific limits to your coverage or specific services that are not covered and this is also determined by your carrier.

“Clinically Appropriate”: For example, if you have a neck or lower back condition, your treatment plan may have to be extended beyond the insurance company’s standardized limitations in order to provide you with full pain relief. At some point later in your treatment, *we may not be able to document significant improvements in range of motion or other objective functional capacity measurements* as the insurers often require. Insurance companies often deny care at that point despite the fact that the treatment continues to manage, reduce or eliminate your pain. This is “clinically appropriate” for your circumstances, but may not be considered “medically necessary” by your insurance carrier.

Your insurance company makes the final determination on whether a service is medically necessary and will be covered by insurance.

Graybar Chiropractic & Rehab Centers has advised me that:

- 1.) Many insurance companies permit collection of payment for services directly from the patient if the patient requests the services and if the patient is informed, in advance, that the services are not covered or may be denied as not medically necessary; and
- 2.) It is ultimately my responsibility to pay for the services rendered in these offices.
- 3.) I understand it is my responsibility to confirm my coverage with my insurance carrier and that Graybar Chiropractic & Rehab Centers may verify such coverage as a courtesy to me, but that Graybar Chiropractic & Rehab Centers cannot be held responsible or liable for inaccurate information provided by my insurance carrier.

I acknowledge I have been informed of and accept the responsibility of being fully and personally responsible for all charges incurred for my care either not covered by my insurance carrier or that my carrier denies as not medically necessary.

My signature below acknowledges that I fully have read and understand the treatment options available to me with Graybar Chiropractic & Rehab Centers and would like to proceed with treatment.

Patient Name: _____

Patient Signature: _____ Today’s Date: _____

Witness Signature: _____ Today’s Date: _____