Railing Chiropractic & Acupuncture

Dr. Christopher Railing

Today's Date: ____/____/____

Your Name: _____ □Male □Female

What do you prefer to be called/Nickname: _____

Date of Birth: _____/_____/_____ Age:_____

Social Security Number (*LAST 4*): __XXX_____-__XX_____-_____

Marital Status: [ ] Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated [ ]Other

Home Address: _____

City: _____ State:_____ Zip:_____

PLEASE CHECK BEST CONTACT NUMBER

□Home Phone: (_____) _____-_____ □Work Phone: (_____)_____-_____

□Mobile Phone: (_____) _____-_____ *Cell Phone Carrier: _____

Preference for Appointment Reminders: □Phone □Email □Text *must supply cell carrier for texting

Email: _____@_____ (Please print clearly)

Occupation: _____

Emergency Contact: _____ Phone: (_____) _____-_____

Spouse's Name: _____ Spouse's Date of Birth (if the insured) _____

Who can we thank for referring us to you: _____

*****Insurance information: Please present insurance card to Receptionist with Driver's License**

I understand that I am financially responsible for all the charges whether paid by my insurance or not. I authorize the use of my signature on all insurance submission and authorize payment of medical benefits to the undersigned or Railing Chiropractic and Acupuncture for the services described on any bill. Dr. Railing may use my health care information and disclose such information to the insurance company and other agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Should the insurance company perform an audit of records and determine that your treatment was not medically necessary or excessive, they may request monies back directly from Railing Chiropractic & Acupuncture. At that time, you can request an appeal but must understand that you, the patient, will be responsible for any monies owed to Railing Chiropractic & Acupuncture for services rendered. This consent will end when my current treatment plan is completed or one year from the date signed below. I authorize the release of any medical or other information necessary to process any claim by Railing Chiropractic & Acupuncture. I also request payment of government benefits either to myself or the party who accepts assignment.

Signature of Patient or Guardian _____ **Date**_____

NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY: Please select if condition applies to **your** medical history:

□ AIDS/HIV	□ Coronary artery disease	□ Hypertension	□ Peptic ulcers
□ Alcoholism	□ Crohn's disease	□ Inflammatory bowel disease	□ Psoriasis
□ Alzheimer's	□ Degenerative joint disease	□ Juvenile Rheumatoid Arthritis	□ PVD (vascular disease)
□ Anemia	□ Depression	□ Kidney disease	□ Renal disease
□ Angina	□ Diabetes	□ Liver disease	□ Rheumatoid arthritis
□ Arthritis	□ Drug Abuse	□ Lyme disease	□ Scoliosis
□ Asthma	□ DVT (blood clot)	□ Migraine headaches	□ Seizure disorder
□ Atrial fibrillation	□ Fibromyalgia	□ Multiple Sclerosis	□ Sleep apnea
□ Enlarged prostate	□ Gallbladder disease	□ Myocardial Infarction	□ SLE (Lupus)
□ Cancer _____	□ GERD (acid reflux)	□ Obesity	□ Spinal stenosis
□ CVA (Stroke)	□ Gout	□ Osteoarthritis	□ Spondyloarthropathy
□ Congestive heart failure	□ Hepatitis	□ Osteoporosis	□ Thyroid disease
□ COPD	□ High Cholesterol	□ Parkinson's disease	□ Valvular disease

Other: _____

PAST SURGICAL HISTORY: Please list all previous surgeries that required anesthesia.

_____ _____

_____ _____

FAMILY HISTORY:

	Father	Mother	Siblings	Grandparent	Other:_____
Arthritis	□	□	□	□	□
Cancer	□	□	□	□	□
Colitis	□	□	□	□	□
Diabetes	□	□	□	□	□
Epilepsy	□	□	□	□	□
Heart Disease	□	□	□	□	□
High BP	□	□	□	□	□
Kidney Disease	□	□	□	□	□
Osteoporosis	□	□	□	□	□
Psoriasis	□	□	□	□	□
Stroke	□	□	□	□	□
Thyroid Disease	□	□	□	□	□

SOCIAL HISTORY:

Tobacco Use: □Yes □No □Former Type: _____ Packs/Day: _____ Years: _____ Year Quit: _____

Alcohol Use: □Yes □No □Former Type: _____ Frequency:_____ Amount/Day:_____ Last Drink:____

Caffeine Use: □Yes □No Type: _____ Amount/Day: _____

Activity: □Moderate □Sedentary □Vigorous Type(s) of exercise: _____ Frequency: _____

Occupation: Employer: _____ Job Title: _____ Work Status: □P/T □F/T □Disabled □Retired

Hand Dominance: □Right □Left □Ambidextrous

NAME: _____ DOB: _____ DATE: _____

REVIEW OF CURRENT SYSTEMS:

Constitutional
□Chills
□Fatigue
□Fever
□Malaise
□Night Sweats
□Weakness
□Weight Gain
□Weight Loss

Cardiovascular
□Chest Pain
□Cyanosis
□Heart Murmur
□Irregular Heartbeat/ Palpitations
□Leg Swelling
□Syncope (fainting)

Skin/Integumentary
□Contact Allergy
□Itchy Skin
□Rash
□Skin Infection
□Skin Lesion

Metabolic/Endocrine
□Cold Intolerant
□Hair Loss
□Heat Intolerant

HEENT
□Blurred Vision
□Double Vision
□Dysphagia (problem swallowing)
□Ear Drainage
□Facial Pain
□Headache
□Hearing Loss
□Hoarseness
□Nasal Congestion
□Ringing in Ears
□Vertigo
□Vision Loss

Gastrointestinal
□Abdominal Pain
□Constipation
□Black Tarry Stools
□Diarrhea
□Heartburn
□Jaundice
□Loss of Appetite
□Nausea
□Vomiting

Neurological
□Difficulty Walking
□Dizziness
□Poor Coordination
□Memory Loss
□Muscles Weakness
□Paresthesia (numbness or tingling)
□Seizures
□Tremors

Psychiatric
□Anxiety
□Depression
□Insomnia

Respiratory
□Chest Pain (respiratory)
□Cough
□Dyspnea (shortness of breath)
□Recent infections
□Known TB exposure
□Wheezing

Genitourinary
□Dysuria
□Frequent Urination
□Hematuria
□Urge incontinence
□Urinary incontinence

Hematological
□Bleeding
□Bruising

Immunological
□Asthma
□Bee sting allergies
□Contact dermatitis
□Environmental allergies
□Food allergies
□Seasonal allergies

Musculoskeletal
□Cervical Pain
□Thoracic Pain
□Lumbar Pain
□Sciatica
□Numbness/Tingling Upper Extremities
□ Numbness/Tingling Lower Extremities

HEIGHT: _____ WEIGHT: _____

NAME: _____ DOB: _____ DATE: _____

MEDICATIONS AND ALLERGIES: Please attach medication list if available.

Medication or Vitamin Name:	Dosage:	Reason for Taking:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Drug Allergies:	Reaction:
1.	
2.	
3.	
4.	
5.	

NOTICE OF PRIVACY PRACTICES

Railing Chiropractic & Acupuncture

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of treatment and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe the rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Giving you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including the information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make any important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to other healthcare providers to assist them in treating you.

FOR PAYMENT: We may disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

INFORMED CONSENT TO CHIROPRACTIC CARE

Railing Chiropractic & Acupuncture

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

Please discuss any questions or concerns you may have with the doctor before signing this consent.

Thereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by any Doctor of Chiropractic employed by Railing Chiropractic & Acupuncture.

I have had/will have the opportunity to discuss with the Doctor and/or with other office or clinic personnel the purpose and benefits of the Chiropractic adjustments and other treatments outlined below.

Alternatives to treatment have been reviewed.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that I will be receiving some or all the following treatment(s):

- Chiropractic Adjustments/Manipulation
- Electric Muscle Stimulation
- Heat/Cold Packs
- Xray(s)
- Traction
- Massage/Therapeutic Exercises and Stretches
- Cold Laser Therapy
- Acupuncture/Cupping

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

Staff Signature _____ Date _____

Doctor's Signature _____ Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Railing Chiropractic & Acupuncture

Acknowledgement Form

I have received the notices of privacy practices and/or I have been provided an opportunity to read it.

Name(Print) _____ Date of Birth_____

Signature _____

Date _____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Railing Chiropractic & Acupuncture** (hereinafter "the Provider") all my rights, title, and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above-named assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expense not covered under my insurance policy will be my responsibility.

I further authorize the provider to negotiate, collect, and settle any claim with any insurance carrier or other third-party payer regarding these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other third party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to finish to Provider copies of all furniture notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations of statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount of payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to the Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.

I have read the foregoing and understand and agree to each other of the above provisions:

Patient's Signature	**Date**

CLIENT SERVICE AGREEMENT

We at Railing Chiropractic & Acupuncture are committed to providing you with the best possible medical care. To achieve this goal, we need your assistance and your understanding of our policies.

- **PAYMENT:** All payments are due at the time services are rendered. We accept cash, credit cards and personal checks. Returned checks are subject to a service charge of $25.00 or 5% of the face value, whichever is greater. Accounts not paid in full may accrue interest at the maximum rate allowed by law. In addition, Railing Chiropractic & Acupuncture may charge a processing fee of $25.00 per month if your account is late or delinquent. In case of default on payment you agree to pay any reasonable collection or attorney fees.

- **APPOINTMENTS:** Office hours are by appointment only. We ask that you call the office to schedule an appointment at 904-551-9283.

- **APPOINTMENT REMINDERS:** Railing Chiropractic & Acupuncture sends out appointment reminders via email, phone or text. We also occasionally send out emails about upcoming events. If you wish to no longer receive appointment reminders, please let us know and we will unenroll you, however, it is still your responsibility to make it to your scheduled appointment at the scheduled time.

- **CANCELLATIONS:** At the discretion of Railing Chiropractic & Acupuncture, late-cancels and no-shows may incur a $25.00 processing fee. To prevent missed appointment charges, patients must call to cancel/reschedule a few hours ahead of time for a chiropractic visit and at least **24 HOURS** for a massage appointment.

- **Affordable Care Act 1557:** Railing Chiropractic & Acupuncture complies with applicable Federal civil rights laws and does *not* discriminate based on race, color, national origin, age, religion, disability, or sex.

- *I have read and fully understand Railing Chiropractic & Acupuncture's Client Service Agreement and I agree to the terms of this agreement. I also understand and agree that the terms of Railing Chiropractic & Acupuncture's Client Service Agreement may be amended at any time without prior notification.*

_____ _____

Signature of Patient or Guardian **Date**