JOHNSTON CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION

Driver's License #: _____ Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address *(if different from above)*: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

E-mail Address: _____

Age: _____ Birth Date: _____ Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced # of Children: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Nearest Relative: _____

Referred By: _____

Date of last physical examination: _____

What operations have you had? _____ When? _____

Serious Illnesses? _____ When? _____

Have You Suffered From:

Dizziness:	☐ Yes ☐ No	Tuberculosis:	☐ Yes ☐ No	Asthma:	☐ Yes ☐ No	Sinus Trouble:	☐ Yes ☐ No
Backache:	☐ Yes ☐ No	Arthritis:	☐ Yes ☐ No	Neuritis:	☐ Yes ☐ No	Anemia:	☐ Yes ☐ No
Heart Trouble:	☐ Yes ☐ No	Headaches:	☐ Yes ☐ No	Digestive Disorders:	☐ Yes ☐ No	Rheumatic Fever:	☐ Yes ☐ No
Diabetes:	☐ Yes ☐ No	Numbness:	☐ Yes ☐ No	Nervousness:	☐ Yes ☐ No	Cancer:	☐ Yes ☐ No

Purpose of this appointment: _____

Other doctors seen for this condition: _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

Describe: _____

What medications or drugs are you taking? _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

Remarks and additional information: _____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: _____

ARE YOU INSURED? ☐ YES ☐ NO COMPANY _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Johnston Chiropractic Clinic 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 Johnston Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: X _____ Social Security # X _____ Date X _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

Information Taken By: _____ Date: _____

Form Approved By The Professional Chiropractic Society of America

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE ANSWER THE FOLLOWING QUESTIONS.

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM Location: _____

How did the accident occur? ☐ Auto Collision ☐ On-the-job Injury ☐ Other: _____

Please describe the circumstances: _____

_____

_____

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did they recommend care at our office? ☐ YES ☐ NO

If it was an auto collision, were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

List the extent of the injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms other than above: _____

Have you lost any days of work? ☐ YES ☐ NO If so, what dates: _____

Insurance Companies Involved:

My Company _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney that has advised you in this case? ☐ YES ☐ NO

Name: _____ Address: _____ Phone #: _____

JOHNSTON
CHIROPRACTIC
CLINIC

DR. PAUL F. JOHNSTON

To the Patient:

The X-rays taken at this office are part of your records. If you need them to be reviewed by another doctor, please have your doctor request these X-rays and will make a copy. A $10.00 fee is required.

Date:_____

Patient Signature:_____

Witness:_____

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HEALTH INSURANCE CLAIM FORM

Driver's Lic:

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE FEMALE	6. INSURED'S I.D. No. or MEDICARE No. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	8. INSURED'S GROUP NO (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED X DATE		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person) X

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE

1
2
3
4

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	26. ACCEPT ASSIGNMENT GOVERNMENT CLAIMS ONLY (SEE BACK) YES NO 30. YOUR SOCIAL SECURITY NO.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO		

*PLACE OF SERVICE CODES

11 – 1041 – OTHER LOCATIONS

JOHNSTON CHIROPRACTIC CLINIC

PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

1. I understand that this authorization is valid from date of signature for seven (7) years.
2. I understand that the purpose or use of the disclosure I am granting is necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payments for that treatment and to carry out its health care operations.
3. I expressly acknowledge that this authorization is voluntary.
4. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
6. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
8. I understand that I may see and copy this information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
9. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
10. This authorization is valid as of ___/___/___, the date I have signed below.

X _____ X _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g.. Guardian, Parent if a minor) Relationship

_____

Witness

JOHNSTON CHIROPRACTIC CLINIC

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agrees as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that my such revocation shall not apply to the extent that the Practice has already taken action in reliance to this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the use and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

X _____
Name of Individual (Printed)

X _____
Signature of Individual

_____
Signature of Legal Representative
(e.g. Guardian and/or Parent if a minor)

_____
Relationship

X Date Signed _____/_____/_____

_____
Witness

JOHNSTON
CHIROPRACTIC
CLINIC

DR. PAUL F. JOHNSTON

ACKNOWLEDGMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services from _____, D.C., at his Chiropractic office, and that I have been advised that the Doctor(s) providing the services is (are) willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either

(a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or

(b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the Doctor(s), or if I have not engaged the services of an attorney;

then payment for services rendered by the above named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

Dated the X_____ day of _____, 20_____.

X_____
Patient's Signature

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

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JOHNSTON
CHIROPRACTIC
CLINIC

DR. PAUL F. JOHNSTON

AUTHORIZATION AND ASSIGNMENT

TO PAUL F. JOHNSTON, D. C.
(Name of Doctor)

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Date: X _____ Signed: X _____

Date of injury: _____

PERTINENT DATA:

Names of insurance companies believed to be involved:

My companies:	Companies of person responsible for accident:
_____	_____
_____	_____
_____	_____

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

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JOHNSTON
CHIROPRACTIC
CLINIC, INC.

DR. PAUL F. JOHNSTON
Chiropractor

RE: Medical Reports and Doctor's Lien

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries on connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: X_____ Patient's Signature: X_____

The undersigned being attorney of record for the above patient does hereby agree to observe the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated: _____ Attorney's Signature: _____

Please date, sign and return one copy to doctor's office.

Keep one copy for your records.

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