Brannon Family Chiropractic

197 East Brannon Road
Nicholasville, KY 40356
(859) 971-0370 (Phone)
(859) 971-0650 (fax)

Patient Information

Date: _____

Social Security # _____

Patient Name:_____

_____

Address:_____

City:_____

State:_____ Zip: _____

Sex: M F Age:_____

Date of Birth: _____

Married Widowed Single Minor Separated Divorced Partnered for _____ Years

Employer/School: _____

Occupation:_____

Phone Numbers

Cell Phone (____)_____

Home Phone (___)_____

IN CASE OF EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone # (___)_____

Medical Consent to Treat

I voluntarily consent to chiropractic care, which may include chiropractic adjustments, x-rays, electrical stimulation, heat, ice, mechanical traction, therapeutic exercises, manual therapy, massage, or other appropriate treatments/modalities by my chiropractor, his/her assistant, or his/her designees, as is necessary in his/her judgment.

This consent is designed to cover all services provided by Brannon Family Chiropractic which do not require an additional "Special Consent Form".

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me or my legal representative.

I have read this form and I fully understand and accept its terms and conditions.

_____ DATE: _____

Signature of Patient, Parent, Guardian or Person Representative

Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

_____
_____
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_____
_____

Vitamins & Supplements

_____
_____
_____
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_____
_____
_____
_____

How did you hear about this office?

_____

Patient Condition

Reason for today's Visit? _____

_____

When did your symptoms appear? _____

_____

Is this condition getting progressively worse?

YES NO UNKNOWN

Rate the severity of your pain on a scale of 1-10 [1 being least pain, 10 severe pain] _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness OTHER

How often does this pain occur? _____

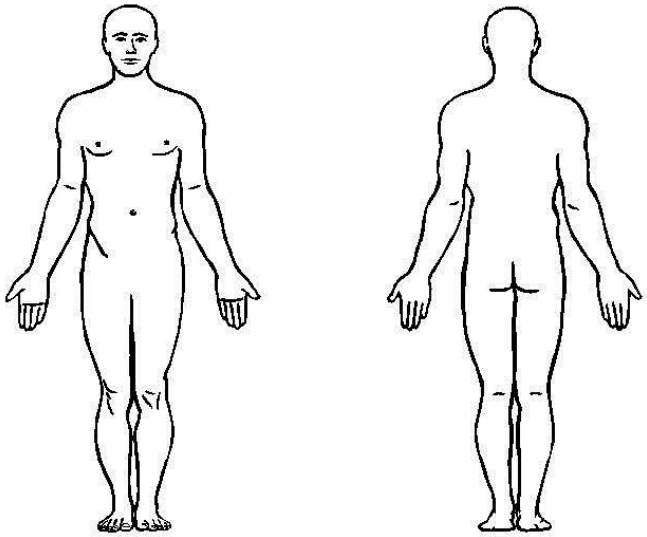
Is the pain Constant or does it come and go?

_____

Does the pain interfere with your daily activity?

Work Sleep Daily Routine Recreation

Are any of the following activities or movements painful to perform? Walking Bending Lying Down



Mark an **X** on the picture above where you are having pain, numbness, or tingling.

Health History

What treatments you already received for your condition? Medication Surgery Physical Therapy Chiropractic Services None Other _____

Name and address of other doctor(s) or Primary Care Physician who have treated you for this condition:

_____

Date of Last:	Physical Exam _____	Spinal X-Ray_____	Dental X-Ray _____
Blood Test_____	Spinal Exam _____	Chest X-Ray_____	Urine Test _____
MRI_____	CT-Scan_____	Bone Scan_____	

Please Circle YES or NO to indicate if you have/had any of the following:

AIDS/HIV YES NO	ALLERGY SHOTS YES NO	ARTHRITIS YES NO	RHEUMATOID ARTHRITIS YES NO
BREAST LUMPS YES NO	CANCER YES NO	DIABETES YES NO	EMPHYSEMA YES NO
HERNIATED DISK YES NO	FRACTURES YES NO	EPILEPSY YES NO	MIGRAINES/HEADACHES YES NO
PACEMAKER YES NO	PINCHED NERVE YES NO	STROKE YES NO	TUMORS/GROWTHS YES NO

Are you pregnant? Yes No

Due Date: _____

Injuries/Surgeries

Please include Dates

Falls:

_____

_____

Head Injuries:

_____

_____

Broken Bones/Dislocation:

_____

_____

Surgeries:

_____

_____

Other Accidents:

_____

_____

Exercise	Work Activity	Habits
None	**Sitting**	**Smoking_____**
Moderate	**Standing**	**Alcohol_____**
Daily	**Light labor**	**Coffee/Caffeine_____**
Heavy	**Heavy Labor**	**High stress level_____**

Patient Specific Functional Scale

Please circle any activities that you are unable to do or have difficulty doing as a result of the injury you are being treated for at Brannon Family Chiropractic; please be as **specific** as possible.

Getting Dressed	Reaching	Pushing	Pulling
Moving in Bed	Getting up From Sitting	Going up/down stairs	Sitting
Standing	Bending	Lifting	Walking
Driving	Sleeping	Hobbies	Sexual Act ivies
Reading	Running	Sports	Working
Lying down	Childcare	Bathing	Housework

For any of the above activities circled please list details about them below. What specifically bothers you, duration [ex. driving ½ hour] and any additional information to help the doctors.

_____

_____

_____

Choose 3 activities that you can currently not do that are interfering with your life the most. In the space provided rate the activity on a scale of 0-10. Zero meaning you cannot perform the task at all and 10 you can do the task just as well as before the injury. [EX: playing with children -2]

Three most important actives you can currently not do.	**0=Unable to Perform At All:**										**10=Able to Perform as well as Before Current Injury**
1.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3.	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____

Employer:_____

Claim Number:_____

Social Security #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out to Brannon Family Chiropractic and mail it directly to 197 East Brannon Rd. Nicholasville, KY 40536.

If my current policy prohibits direct payments to the doctor, I hereby instruct and direct you to make the check payable to me and mail it to 197 East Brannon Rd. Nicholasville, KY 40536 as follows:

C/O

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mention assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at Lexington, KY the _____ day of _____20____.

Signature of Policyholder:_____

Signature of Claimant [if other than policyholder] _____

Witness:_____ DATE: _____

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Records Release

Personal/Confidential

TO: _____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO

Lindsay O'Nan, D.C.

Caroline Kasik, D.C.

This authorization or photocopy will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information. All information will remain confidential and personal.

Name: _____

Signature: _____ Date: _____

Records Release

Patient: _____

DOB:_____

SS#:_____

Brannon Family Chiropractic Office Financial Policy

Cash

1. **All patients are considered to be on a cash basis unless other applicable coverage listed in "other coverage" section below applies.**
2. **First day services are to be paid in full unless arrangements have been made prior to services rendered.**
3. **This office may make payment plan arrangements on a individual basis. Any such arrangements will be discussed during your Report Of Findings on your second visit.**

Other Coverage

1. **We accept assignments for most Workers Compensation plans.**
2. **We accept assignments for Personal Injury (Includes Auto/PIP & liability insurance)**
3. **We accept assignments for BlueCross BlueShield (Anthem), Humana, Aetna, Bluegrass Family Health, United Health Care, Cigna. For other insurance carriers we do file this as a service to you.**
4. **We accept assignments for Medicare and Medicaid.**
5. **YOU ARE RESPONSIBLE FOR YOUR ENTIRE BILL REGARDLESS OF YOUR INSURANCE COMPANY'S FAILURE TO PAY ANY OF THE ANTICIPATED CHARGES FOR ANY REASON. WE ARE NOT A MEDIATOR BETWEEN YOU AND YOUR INSURANCE COMPANY, AND WE WILL NOT ENTER INTO ANY DESPUTE WITH THEM, AS YOUR CONTRACT IS BETWEEN YOU AND YOUR INSURANCE COMPANY.**
6. **Any services not covered by the insurance company will be the patient's responsibility.**
7. **This office will submit your claims to your insurance company as a courtesy to you. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent.**
8. **ANY DENIED OR DISPUTED CLAIMS WILL BE TREATED AS UNCOVERED SERVICES AND YOU WILL BE EXCPECTED TO PAY SUCH CHARGES ON A TIMELY BASIS.**
9. **If you are referred to another specialist or discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately. Regardless of any previous arrangements or discounts.**
10. **IF YOU HAVE ANY QUESTIONS CONCERNING THIS OR ANY OTHER MATTER, PLEASE SPEAK WITH THE OFFICE MANAGER PRIOR TO SEEING THE DOCTOR.**

**** AS A COURSTEY TO YOU, WE CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR POLICYS COVERAGE. HOWEVER, THIS IS NOT A GUARANTEE OF BENEFITS. BE SURE TO CONTACT YOUR INSURANCE COMPANY IF YOU ARE UNSURE OF YOUR CHIROPRACTIC COVERAGE AND BENEFITS****

I HAVE READ AND UNDERSTAND THE "OFFICE FINANCIAL POLICY" AS STATED ABOVE. I AGREE TO ABIDE BY THESE POLICIES LISTED ABOVE.

Signature: _____ Date: _____

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Notice of Privacy Practices

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. We care about your patient privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice: Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g. a billing service), sites, and locations of this practice may share medical information with each other for treatment, payment purposes, or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For treatment: We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about your health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent of Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To Workers Compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- Other healthcare providers treatment activities
- Other covered entities and providers payment activities
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization: Other uses and disclosures of medical information not covered by this Notice of laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorizations, that we required retaining your records we have provided you.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions: You have the right to request a restriction of limitation on the medical information we use or disclose about you for treatment, payment, or health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communication: You have the right to request how we should send communications to you about medical matters, and where you like those communication sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes; information compiled for use in a civil, criminal, administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decision about you, reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if the information was not created by us, is not a part of medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to appropriate portion of your record.

Right to an Accounting of Non- Standard Disclosure: You have the right to request a list of disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 1, 2005. Your request should indicate in what form you want the list. The first list you request within 12- month period will be free. For additional lists, we reserve the right to charge you for the cost of providing this list.

Changes to This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information in the future.

ACKNOWLEDGMENT

OF PRIVACY PRACTICES

I understand and have been provided with a copy of Brannon Family Chiropractic Privacy Practices. I understand I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to object to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Signature: _____ Date: _____

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I, _____ understand that payment for services is due at the time services are rendered, unless other arrangements have been made with Dr. Lindsay O'Nan. I understand that Dr. Lindsay O'Nan is the only person who can change the payment policy at Brannon Family Chiropractic, P.S.C.in the event that my account is turned over to collections for nonpayment at the 90 day mark, I understand and accept that my past due amount will be assessed an additional fee of 40%. I acknowledge that I will be responsible for paying this fee in addition to the outstanding balance on my account.

Signature: _____ Date: _____