WV CHIROPRACTIC AND WELLNESS
CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ **Preferred Name/Nickname**: _____
Home Address: _____
City:_____State:_____Zip:_____
Home Telephone: _____ Mobile Phone: _____
Email Address:_____*(For appointment reminders, announcements and clinic news)*
Birthdate: _____SSN (only required if referred by VA Hospital):_____
Marital Status: S M D W # of Children:____ Females: Are you currently pregnant? Yes No
Occupation: _____ Student? Part time Full time
Parent/Guardian (if applicable): Please provide your name, address and phone # below:
_____
_____
Employer's Name and Phone # (if known):_____
Emergency Contact, Phone # and Relation: _____
Family Doctor and Clinic Name: _____
How Did You Hear About Our Office? □ Social Media □ Google □ Referred by: _____

Please list the type of insurance you will be using (write "None" if no insurance):
Primary Insurance: _____Secondary Insurance Company: _____
Primary Policy Holder: (*This is generally the family member that gets insurance through their employer)*
□ Self □ Spouse/S.O. □ Parent □ Other: Name:_____DOB:_____
Address (if different than yours):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Daniel Boggs & WV Chiropractic and Wellness. This is a direct assignment of my rights and benefits under my policy. All payments are to be issued to Dr. Daniel Boggs and mailed to 2729 Main St., Hurricane, WV 25526. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand insurance policies are an arrangement between the insurance carrier and myself, and that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Privacy: By signing below, you certify the following: I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly or indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

Patient's Signature:_____Date:_____
Guardian's Signature Authorizing Care:_____Date:_____

CONFIDENTIAL PATIENT INFORMATION (page 2)

Please list all medications (both prescription and over the counter), vitamins and supplements that you are taking.
You may also provide us with a written list on your next visit if needed.

Name:	How long have you taken this & for what condition?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Any Previous Accidents, Fractures, Surgeries, Hospitalizations and Illnesses

1. Type: _____When: _____ Hospitalized? Y N
2. Type: _____When: _____ Hospitalized? Y N
3. Type: _____When: _____ Hospitalized? Y N
4. Type: _____When: _____ Hospitalized? Y N

Patient Medical History: Please Check All Of The Following That You Have Now, Or Have Had In The Past (Write "N" for now, "P" if you've had it in the past, and leave blank if you've never had it)

___ADD/ADHD	___ Depression	___ Hepatitis	___ Miscarriage
___ Alcoholism	___ Diabetes	___ High Blood Pressure	___ Multiple Sclerosis
___ Allergies	___ Diarrhea	___ High Cholesterol	___ Low Back Pain
___ Alzheimer's	___ Eczema	___ High Blood Sugar	___ Neck Pain
___ Anemia	___ Emphysema	___ HIV/AIDS	___ Arm/Leg Pain
___ Appendicitis	___ Epilepsy/Seizures	___ Irregular Periods/Cramps	___ Numbness/Tingling
___ Asthma	___ Fibromyalgia	___ Irritable Bowel	___ Erectile Dysfunction
___ Arthritis	___ Gallbladder	___ Kidney Infections/Stones	___ Vaginal Dryness
___ Back Pain	___ Goiter	___ Low Blood Pressure	___ Ulcers
___ Cancer	___ Gout	___ Low Blood Sugar	___ Parkinson's Disease
___ Celiac Disease	___ Headaches	___ Lyme Disease	___ Pneumonia
___ Chronic Fatigue	___ Heart Disease	___ Lupus	___ Rheumatoid Arthritis
___ Constipation	___ Heart Attack	___ Migraines	___ Ringing In Ears
___ Sinus Problems	___ Stroke	___ Thyroid Problems	___ Dizziness

Family History: Do you have a family history of any of the following?

High Blood Pressure:	Mom	Dad	Sibling	Grandparent
Heart Disease:	Mom	Dad	Sibling	Grandparent
Stroke:	Mom	Dad	Sibling	Grandparent
Diabetes:	Mom	Dad	Sibling	Grandparent
Arthritis:	Mom	Dad	Sibling	Grandparent
Cancer:	Mom	Dad	Sibling	Grandparent

Please mark any of the following that apply:

Smoking: No/Yes ___ Packs/day Smokeless tobacco: ___ containers/day Alcohol: ___ drinks per day/week
Coffee/Tea: ___ Cups/day Sodas (Diet or Regular?): ___ Drinks per day Do you use artificial sweeteners? Y N
How many days per week do you exercise?____ What type of exercise? None Light Moderate Strenuous
Have you noticed any unexplained or rapid weight change in the last 6 months? Yes No ____pounds
Have you experienced any type of infection recently? Yes No Describe: _____

REASON FOR OFFICE VISIT

CHIEF COMPLAINT

1._____

How long has this been an issue? _____ How bad is this complaint? 1-10 _____

What does the pain feel like? ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Numb ☐ Tingling ☐ Stiff

Since the onset, it has: ☐ Stayed the same ☐ Gotten better ☐ Gotten Worse

Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Hobbies/recreation

What makes it better? _____ ☐ Nothing

What makes it worse? _____ ☐ Nothing

Have you had this issue treated before? ☐ Yes ☐ No

If yes, what type of treatment and who was the Doctor/practitioner? _____

What were the results of the treatment? ☐ No Change ☐ Better ☐ Worse ☐ Other _____

OTHER COMPLAINTS

2._____

How long has this been an issue? _____ How bad is this complaint? 1-10 _____

What does the pain feel like? ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Numb ☐ Tingling ☐ Stiff

Since the onset, it has: ☐ Stayed the same ☐ Gotten better ☐ Gotten Worse

Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Hobbies/recreation

What makes it better? _____ ☐ Nothing

What makes it worse? _____ ☐ Nothing

Have you had this issue treated before? ☐ Yes ☐ No

If yes, what type of treatment and who was the Doctor/practitioner? _____

What were the results of the treatment? ☐ No Change ☐ Better ☐ Worse ☐ Other _____

3._____

How long has this been an issue? _____ How bad is this complaint? 1-10 _____

What does the pain feel like? ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Numb ☐ Tingling ☐ Stiff

Since the onset, it has: ☐ Stayed the same ☐ Gotten better ☐ Gotten Worse

Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving ☐ Hobbies/recreation

What makes it better? _____ ☐ Nothing

What makes it worse? _____ ☐ Nothing

Have you had this issue treated before? ☐ Yes ☐ No

If yes, what type of treatment and who was the Doctor/practitioner? _____

What were the results of the treatment? ☐ No Change ☐ Better ☐ Worse ☐ Other _____

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

WV Chiropractic and Wellness: Disclosure of Protected Health Information

The effective date of this Notice of Privacy Practices is 01/01/2019

Protecting the privacy of your personal health information (PHI) is important to us. This acknowledgement is a summary of the full Notice of Privacy Practices which outlines in detail how information about you may be used and disclosed and how you can get access to this information. The full policy refers to guidelines outlined in federal mandates of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Omnibus and is available upon request and posted on our Practice's website.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities and for treatment, payment, or practice operations. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may access copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain an accounting of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

In addition, I hereby authorize the release of information to personal acquaintances named below (and relationship) or fill in none.

1) _____ Relationship: _____

2) _____ Relationship: _____

I acknowledge that I have access to the full Notice of Privacy Practices for protected health information. I hereby grant consent for [Practice Name] to release any information necessary for my course of treatment, payment or healthcare operations.

_____

Date Printed Name Signature

WV CHIROPRACTIC AND WELLNESS
Dr. Daniel Boggs, D.C., FIAMA, CFMP
2729 Main Street, Hurricane WV 25526
PH: (304) 518-5179

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures included: physical examination, testing, physio-therapy, physical medicine, physical therapy procedures, acupuncture, nutritional therapy, etc. on me by the doctor of chiropractic names above and/or other assistants and /or licensed practitioners.

I understand, as with all health care procedures, that there are certain complications which may arise during chiropractic treatments. Although rare, these complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers Syndrome, myelopathy, and rib strains, fractures and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

_____

Acupuncture specific: I understand that acupuncture is performed by the insertion of single use of sterile needles through the skin, to normalize the body's physiological functions. Other methods of stimulation used may include cupping, laser, microcurrent, vibration, and/or acupressure.

Acupuncture is typically a safe method of treatment however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

Pregnancy: I will notify the Doctor should I become pregnant or if I am in the process of trying to become pregnant so my practitioner can avoid points that could induce miscarriage. If you are pregnant or trying to become pregnant, we will require clearance from your obstetrician before treatment.

Electro- Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

_____

I do not expect the doctor to be able to anticipate all the risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I understand that if I have any questions about the nature, risks and purposes of chiropractic treatment and other recommended procedures that it is incumbent upon me to speak with the Doctor about my questions during my appointment. I will not proceed with care unless my questions are answered satisfactorily. I also understand that specific results are not guaranteed.

I have read (or have read to me) the above explanation of the treatments rendered in this office. I state that I have been informed and weighed the risks involved in chiropractic and/or acupuncture treatment and procedures provided at this office. I have decided that it is in my best interest to receive chiropractic and/or acupuncture treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment.

Sign only after you understand and agree to the above.

_____ _____

Printed name of patient **Patient (or representative) Signature**

_____

Date

Dr. Daniel Boggs, DC
WV Chiropractic and Wellness
2729 Main Street
Hurricane, WV 25526
Phone: (304) 518-5179 - Fax: (304) 586-6586

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Dear Medical Records Department,

I authorize the release of the below listed records for services rendered by you or under your supervision. This information will be used to further assist in my medical care and should be faxed to the number listed above. If you are unable to fax this information, mail it to the above listed address.

Thank you for your kind cooperation and consideration in this manner.

Patient: I understand that I may revoke this notification in writing at any time, except to the extent that action has already been taken in accordance with this authorization. If this authorization has not been revoked, it will terminate in 5 years from the date of my signature below.

I understand that this practice will provide care to me whether or not I provide this authorization.

I understand that my information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Signature: _____ Date: _____

Guarding Signature:_____Date: _____

*** *Clinic Use Only. Do not write in this box*

To: _____
_____
_____

RE: _____
DOB: _____
SSN: _____

Records requested:

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam forms
_____Daily chart notes
_____X-ray Reports
_____X-ray Films
_____Other, specify:
_____