exodus international CHIROPRACTIC charlotte, NC

Date: _____

PERSONAL INFORMATION:

Name _____ Goes By: _____DOB _____

Address _____City _____ State_____ Zip_____

Phone (Cell) _____ Phone (Home)_____Sex: M/F Marital Status: S/M/D/W

Occupation _____ Social Security #_____

Spouse's Name_____# of Children _____Ages_____

Email address_____

How did you hear about us? _____

HEALTH HISTORY:

Reason(s) for seeking care: _____

When did this injury or condition begin: _____

How did this happen: _____

Please Circle:

Type of injury: Pain/ Numbness/ Swelling/ Muscle spasms/ Headache/ Tightness/ Stiffness/ Tingling/ Weakness/

Other:_____

Quality: Sharp/ Dull/ Aching/ Throbbing/ Crushing/ Stabbing/ Local/ Radiating/ Burning/ Migraine/ Tension/ Hormonal/ Sinus/

Other:_____

Does the pain travel: _____

Timing: Constant/ Frequent/ Intermittent/ Occasional/ Infrequent/ Other:_____

Severity: 0(none)/ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10(disabling)

Daily Activities: Effects of current conditions on performance such as:

Sleeping/ Running/ Sitting/ Standing/ Other:_____

How long? Extended Periods/ 5 min/ 10 min/ 30min/ 45min/ 1hour/ 2hours/ Other:_____

Result in pain: 0(none)/ 1/ 2/ 3/ 4/ 5/ 6/ 7/ 8/ 9/ 10(disabling)

What activities make your condition/pain worse?_____

What activities make your condition/pain better? _____

List any other doctors seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____

Have you received chiropractic treatment previously? __ Yes __ No If yes, explain:_____

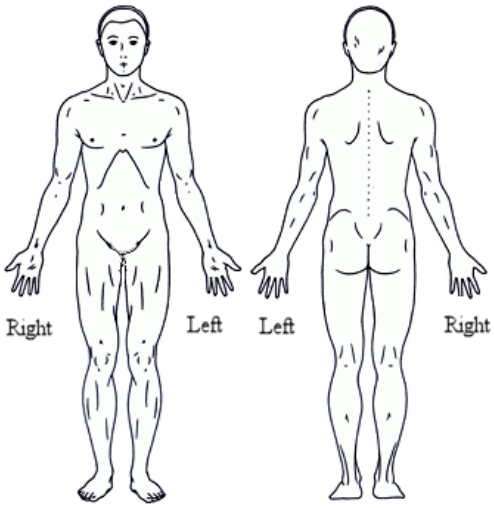
Past traumas or hospitalizations not related to current condition: _____

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

If yes, explain: _____

Are you currently taking medication? _____ If so, list medications and why:_____

_____



List the approximate dates of any surgery or previously treated conditions:_____

_____

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =	Dull Ache	OOO
Burning	XXX	Sharp/Stabbing	/ / /
Pins, Needles	+ + +	Other _____	^ ^ ^

Is this condition interfering with work? Y/N

Sleep? Y/N

Normal Daily Routine? Y/N

Extended activities like Exercise Y/N?

Since this condition started is it getting the same, better, or worse?

_____

Please mark any item below with a "C" for any current sign or symptom you have or "P" for anything you've previously had: (if neither leave blank)

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain

Pregnant at this Time Y/N

_____
_____
_____

INITIAL NERVE SYSTEM PROFILE

Does your job require you remain in long term stressful postures? _____
(*i.e. all day seating, repeated lifting, long term computer use)*

Any past spinal traumas? _____

Have you participated in collision, quick burst, or repetitive motion sports such as: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____

Trauma as a child? Ex: fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, birth trauma _____

Do you have any root canals? ___Y ___N. If so, when? _____
Do you have any Amalgam (mercury) fillings? _____

---I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

_____

Patient Signature Date

Females only regarding X-ray/Imaging studies

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____/_____/_____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____

Patient Signature Date

Medicare Advanced Beneficiary Notice:

All Medicare patients are responsible for their $155 deductible for chiropractic care. Medicare does not cover exams, but requires them before any adjustments of the spine can be performed. Medicare does not cover x-rays, but they may be necessary for treatment to occur. Medicare provides coverage for chiropractic adjustments when Medicare rules are met. The patient is responsible for any services that are not covered by Medicare or supplemental insurance.

Assignment and Release:

I agree to treatment by my doctor and such person's of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc. and hereby provide my consent for treatment. I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Brandon and Natalie Mahaffy (Doctors of Chiropractic) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

When you sign the consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You have the right to ask us to restrict the users or

disclosers made for the purposes of treatment, payment, or health care operations. Please refer to our Notice of Privacy Practices for further information.

Patient Name (Print)

Patient Signature Date Witness Initials

ACCIDENT INFORMATION: (only fill out if you are strictly here because of an auto accident)

Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____

Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

Date of accident_____ Fault_____

Do you have medical pay benefits on your auto insurance?__Yes__No__Don't know

Auto Insurance Company_____Claim Number_____

Agent Name_____Phone Number_____

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.
Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an

instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. BRANDON AND DR. NATALIE MAHAFFY TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS ____ DAY OF _____, 20___

Patient Signature

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Exodus Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Exodus Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Exodus Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to Exodus Chiropractic to use my name on a welcome board, referral board, and birthday board.
- I give permission to Exodus Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to Exodus Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Exodus Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Exodus Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Exodus Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Exodus Chiropractic. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Exodus Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Exodus Chiropractic will not refuse to provide treatment however, it will not be possible for Exodus Chiropractic to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Exodus Chiropractic will be unable to contact me 3) all contact with Exodus Chiropractic regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____