APPLICATION FOR TREATMENT AT THE OFFICE OF JAMES J. HETHER, D.C.

Personal Information:

Name_____Age:_____Today's Date: _____
Address:_____City:_____State:_____Zip:_____
Primary Medical Doctor:_____Sex:_____Date of Birth: _____
Home Phone #:_____Cell Phone # _____
Marital Status:_____Number of children:_____
Employer:_____Job Title:_____
Work Phone #:_____Name of Spouse: _____
Name of Nearest Relative/Friend:_____Phone #: _____
Email:_____Who Referred You: _____
Would you like to receive our monthly newsletter via e-mail? ☐ Yes, ☐ No

Financial and Insurance Information:

Name of person responsible for payment: _____
Do you have insurance? ☐ Yes ☐ No If Yes, Insurance Company Name:_____
Name of Insured: _____
Relationship to Insured: ☐ Self, ☐ Spouse, ☐ Child, ☐ Other
Check here if we may make a photocopy of you insurance card: ☐
If not, or you do not have your insurance card with you, please provide us with your insurance information. There is no need to complete this if we have a copy of your insurance card.
Policy #:_____Group #: _____
Employee ID #:_____Medicaid #: _____
How will payment be made? ☐ Cash, ☐ Check, ☐ Charge Card

_____ _____
Patient's Signature Signature of Guardian

Current Complaint:

Please describe your current complaints and then check all that apply: _____
_____
_____

☐ Headaches	☐ Neck pain	☐ Neck stiffness	☐ Upper back pain
☐ Upper back stiffness	☐ Mid back pain	☐ Mid back stiffness	☐ Low back pain
☐ Low back stiffness	☐ Pain traveling down the leg (☐ right leg ☐ left leg)		
☐ Neck restriction	☐ Pain traveling down the arm (☐ right arm ☐ left arm)		
☐ Right shoulder pain	☐ Left shoulder pain	☐ Right arm pain	☐ Left arm pain
☐ Right hand pain	☐ Left hand pain	☐ TMJ pain	☐ Chest pain
☐ Fatigue	☐ Anxiety	☐ Depression	☐ Irritability
☐ Digestive troubles	☐ Constipation	☐ Diarrhea	☐ Nausea

☐ Numbness: describe where_____
☐ Bruising: describe where _____

Have you treated with any other Physicians for this condition? ☐ Yes, ☐ No If yes, please provide us with their names and office locations:

_____
_____
_____

Past Medical History:

Have you had any broken bones? ☐ Yes, ☐ No If yes, please list with dates: _____

_____

Have you had any surgeries? ☐ Yes, ☐ No If yes, please list with dates: _____

_____

Have you had any past major traumas (Including Auto/ motorcycle Accidents? ☐ Yes, ☐ No If yes, please list with dates: _____

_____

General Health History:

Please check all that apply:

☐ Cancer	☐ Heart Attack	☐ Hypertension	☐ Stroke
☐ Diabetes	☐ Migraines	☐ Muscle Sclerosis	☐ Muscular Dystrophy
☐ Asthma	☐ Sinus Problems	☐ Epilepsy	☐ Dizziness
☐ Tuberculosis	☐ Hepatitis	☐ Psoriasis	☐ HIV/Aids

Are you pregnant? ☐ Yes, ☐No If yes, what is you due date? _____

Do you have a pacemaker ☐ Yes, ☐No

Family Health History:

Please check all that apply:

☐ Diabetes ☐ Heart Disease ☐ Multiple Sclerosis ☐ Rheumatoid Arthritis ☐ Stroke ☐ Cancer

Complete this section if your office visit is due to an accident or injury:

Type of injury: ☐ Auto, ☐ workman's comp, ☐ sport, ☐ fall, ☐ Other_____

Date of Accident/Injury:_____Time of Day: _____

Date pains first began:_____City/State accident occurred in: _____

Briefly Describe this Accident/Injury: _____

_____

_____

If your injuries are from an automobile accident, please complete this section:

Did you have your seat belt on: ☐ Yes, ☐ No How many passengers were in your vehicle? _____

Did your airbag deploy: ☐ Yes, ☐ No, ☐ My vehicle does not have an airbag

Describe where you were sitting, at the time of the accident: _____

Which of the following best describes your accident: ☐ Head on Collision

☐ Rear end collision ☐ T-bone collision ☐ Ran off the road ☐ Other_____

List any part of your body that made contact with the interior of the car: (example chest against the steering wheel.) _____

_____

Where you taken to a hospital: ☐ Yes, ☐ No

If Yes, how did you get there: ☐ Ambulance, ☐ Friend/family, ☐ Drove ones self

Estimated speed of your vehicle at time of the accident:_____And the other vehicle: _____

Were your brakes applied before impact: ☐ Yes, ☐ No Did you brace for the accident: ☐ Yes, ☐ No

Were you involved in any previous automobile accident: ☐ Yes, ☐ No

If yes, please provide the date(s), description of accident(s), and physicians/hospitals treated with:

_____

_____

Patient's Name:_____Date of Birth: _____

Office Policy for the Chiropractic office of James J. Hether D.C., P.L.

Financial Terms:

Office accepts cash, checks, or credit cards as forms of payment. Payment for services, co-pay, insurance and or deductible are expected on the day of service.

Concerning Insurance:

1. Patients who carry health insurance should remember that professional services are rendered and charged to the patient. If you have insurance our office will file you claims to your insurance company. Our office will call and verify your insurance coverage. Your insurance company will inform us that the benefits are not a guarantee for payment and all claims are subject to review and your coverage will be determined at the time of the claims are received.
2. Insured patients are expected to take care of their fees as services are rendered, unless other financial arrangements are made in advance. Even though an insurance claim is filed, you may receive a statement each month if your account has a balance due. If our office has a problem with your insurance company we may ask your help is contacting your insurance company on this matter.

Informed Consent:

3. I herby request and consent to performance of chiropractic procedure, included various modes of physical therapy and diagnostic x-ray, on me (or the patient named above, for whom I am legally responsible) by the doctor of chiropractic James J. Hether, D.C., P.L. and /or other licensed doctor of chiropractic who now or in the future work at the clinic or office above or any other locations for the this clinic or office.
4. I will have an opportunity to discuss with the doctor of chiropractic and /or with other office or clinic personnel the nature and purposed of chiropractic adjustments and other procedures. I understand that results are not a guaranteed.
5. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there is some risk to treatment, including but not limited to fractures, disc injury stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complication, and will rely upon the doctor to exercise judgment during the course of the procedure which the doctors feels at the time, based upon the facts then known to him in my best interest.

Assignment of Benefits:

6. I hereby assign and transfer to James J. Hether, D.C., P.L. any and all causes of action that exist against my insurance company for unsatisfied medical billing. My attorney and/or insurance company are hereby requested and authorized to pay direct to James J. Hether, D.C., P.L., any monies due him on my account, the same to be deducted from any settlement made on my behalf. Further understood that I, the undersigned, agree to pay James J. Hether, D.C., P.L., the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company refuses to pay my claim.

General Agreement:

7. A copy of this form shall be as valid as the original.
8. I authorize the release of any medical information necessary to any third party requiring such information for the purpose of conveying credit to my account.
9. I permit this office to endorse remittances for the conveyance of credit to my account.
10. James Jeremy Hether D.C., P.L. has my permission to treat my minor children and me.
11. I have read, or have had read to me the above consent. I also, realize that I can ask any questions about its content prior to signing below. I also, realize that by signing below, I agree to the content and that this consent from covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DATE:_____ SIGNATURE OF PATIENT: _____

Signature of PARENT or GUARDIAN of minor child: _____

WITNESS: _____

Patient Consent for Use and Disclosure of Protected Health Information

JAMES J. HETHER D.C. P.L

I hereby give my consent for JAMES J. HETHER D.C. P.L. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

JAMES J. HETHER D.C. P.L's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. JAMES J. HETHER D.C. P.L reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to JAMES J. HETHER D.C. P.L at 2917 SOUTH WOODLAND BLVD, DELAND, FL 32720.

With this consent, JAMES J. HETHER D.C. P.L may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, JAMES J. HETHER D.C. P.L may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, JAMES J. HETHER D.C. P.L may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that JAMES J. HETHER D.C. P.L restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to JAMES J. HETHER D.C. P.L's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, JAMES J. HETHER D.C. P.L may decline to provide treatment to me.

DATE:_____ SIGNATURE OF PATIENT: _____

Signature of PARENT or GUARDIAN of minor child: _____

WITNESS: _____

James Jeremy Hether, D.C.

Chiropractic Physician

2719 South Woodland Blvd.
DeLand, FL 32720
Phone: (386) 734-0702
Fax: (386) 734-6924

Name: _____

DOB: _____

Please list all prescriptions by name, milligram/ units and frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Medications you are allergic to:

1. _____
2. _____
3. _____
4. _____
5. _____

___I do not take any medications.

Signature:_____Date:_____