MCWHORTER CHIROPRACTIC **Date** ___________________________

LAST NAME _______________________FIRST NAME________________ MIDDLE INITIAL ____ PREFER TO BE CALLED _________________________

ADDRESS____ CITY_____________________ STATE_________ ZIP CODE______________________

CELL PHONE_____________________________ HOME PHONE_________________________ BIRTHDATE________________________________

GENDER____MALE ___FEMALE SOC. SEC. # _________________________ EMAIL ____

STATUS: ___MINOR ___SINGLE ___MARRIED ___DIVORCED ___ SEPARATED ___WIDOWED

REFERRAL SOURCE ___NEWSPAPER ___INTERNET ___FAMILY/FRIEND ___EXISTING PATIENT (NAME)________________________________

NAME OF PRIMARY INSURANCE CARD HOLDER ____________________________ BIRTHDATE OF PRIMARY CARDHOLDER____________________

EMPLOYER ____OCCUPATION____

APPOINTMENT REMINDER PREFERENCE - PLEASE CHECK PREFERENCE BELOW AND PROVIDE NEEDED INFORMATION.

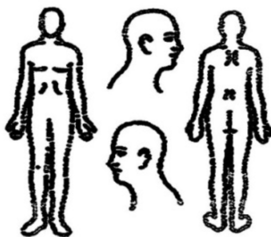
______**TEXT** PHONE NUMBER_________________________
CHECK CELL CARRIER: ____AT&T ____BLUEGRASS ____VERIZON ____ SPRINT _____TMOBILE ____OTHER_______________________________

____**EMAIL** (PLEASE ENTER ADDRESS IN UPPER DEMOGRAPHIC SECTION) ____**PHONE #** ____

PLEASE CHECK ALL THAT APPLY TO YOU:

__RECENT INFECTION
__HIGH BLOOD PRESSURE
__RECENT FEVER
__HIV/AIDS
__DIABETES
__DIZZINESS/FAINTING
__URINARY RETENTION
__AORTIC ANEURYSM
__CANCER/TUMOR
__STROKE (DATE______)
__NUMBNESS IN GROIN/BUTTOCKS
__OSTEOPOROSIS
__RECENT TRAUMA
__PROSTATE PROBLEMS
__FREQUENT URINATION
__PREGNANCY #__
__EPILEPSY/SEIZURES
__VISUAL DISTURBANCES
__ARTHRITIS
__LOW/MID BACK PAIN
__ABNORMAL WEIGHT LOSS OR GAIN
__CORTICOSTEROID USE
__NECK PAIN
__HEART DISEASE
__HISTORY OF ALCOHOL USE
__HISTORY OF DRUG USE
__LUNG/BREATHING ISSUES

Mark an X on the areas where you are experiencing pain.



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DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
____
____
HOW HAVE YOUR SYMPTONS INTERFERED WITH YOUR DAILY ACTIVITIES?
___NONE __MINOR __MODERATELY __EXTREMELY

SYMPTONS BEGAN ON______________________________________

CIRCLE YOUR PAIN LEVEL – 0 EQUALS NO PAIN THRU 10 WHICH EQUALS SEVERE PAIN 0 1 2 3 4 5 6 7 8 9 10

RATE YOUR CURRENT OVERALL HEALTH __EXCELLENT __VERY GOOD ___GOOD ____POOR

Family History: If a parent has a history of any illness below, please check the corresponding box.

Illness	Mother	Father
High Blood Pressure		
Heart Disease		
Stroke		
Diabetes		
Cancer		
Emphysema		
Osteoporosis		
Digestive Problems		
Kidney Disease		
Arthritis		
Ulcers		
Thyroid Problems		
Asthma		
Seizures		
Mental Illness		
Pace Maker		
Other ___________		

HAVE YOU HAD SPINAL XRAYS, MRI, CT SCAN? __NO __YES WHERE__________________________________ WHEN____________________________

ACTIVITY OF DAILY LIVING

Name: ____ Date: ____

Please check the number in each category that best describes your pain or activity level relating to your pain or problem. If it doesn't apply to your issue, please check 0.

Pain Intensity (BFN)
___0 No pain
___1 Mild pain
___2 Moderate pain
___3 Severe pain
___4 Worst pain possible

Sleeping (BFN)
___0 Perfect sleep
___1 Mildly disturbed sleep
___2 Moderately disturbed sleep
___3 Greatly disturbed sleep
___4 Severely disturbed sleep

Personal Care (BFN) (Washing, Dressing, etc.)
___0 No pain – no restrictions
___1 Mild pain – no restrictions
___2 Moderate pain – need to move slowly
___3 Moderate pain – need assistance
___4 Severe pain – need 100% assistance

Travel (BFN)
___0 No pain on long trips
___1 Mild pain on long trips
___2 Moderate pain on long trips
___3 Moderate pain on short trips
___4 Severe pain on short trips
___5 Can't travel due to severity of pain

Work (NF)
___0 Can do usual work plus unlimited extra work
___1 Can do usual work – no extra work
___2 Can do 50% of usual work
___3 Can do 25% of usual work
___4 Cannot work

Recreation (BFN)
___0 Can do all activities
___1 Can do most activities
___2 Can do some activities
___3 Can do limited activities
___4 Cannot do any activities

Frequency of Pain (F)
___0 No pain
___1 Occasional pain – 25% of the day
___2 Intermittent pain – 50% of the day
___3 Frequent pain – 75% of the day
___4 Constant pain – 100% of the day

Lifting (BFN)
___0 No pain with heavy weight
___1 Increased pain with heavy weight
___3 Increased pain with light weight
___4 Increased pain with any weight

Walking (BFN)
___0 No pain – any distance
___1 Increased pain after 1 mile
___2 Increased pain after ½ mile
___3 Increased pain after ¼ mile
___4 Increased pain with all walking
___5 Cannot walk

Standing (BF)
___0 No pain after several hours
___1 Increased pain after several hours
___2 Increased pain after 1 hour
___3 Increased pain after ½ hour
___4 Increased pain with any standing
___5 Cannot stand

Reading (N)
___0 I can read with no pain
___1 I can read with slight pain
___2 I can read with moderate pain
___3 I can't read as much due to moderate pain
___4 I can't read as much due to severe pain
___4 I can't read at all due to severe pain

Headaches (N
___0 No headaches
___1 Slight infrequent headaches
___2 Infrequent moderate headaches
___3 Frequent moderate headaches
___4 Frequent severe headaches
___5 I have headaches almost all of the time

Concentration (N)
___0 Can concentrate fully with no difficulty
___1 Can concentrate fully with slight difficulty
___2 Have a fair degree of difficulty concentrating
___3 Have a lot of difficulty concentrating
___4 Concentrating is extremely difficult
___5 I cannot concentrate

Changing Degree of Pain (BN)
___0 Pain is rapidly improving
___1 Pain fluctuates but is improving
___2 Pain seems to be improving slowly
___3 Pain has had no change
___4 Pain is gradually getting worse
___5 Pain is rapidly getting worse

Sitting (B)
___0 I can sit in any chair as long as I want
___1 I can only sit in my favorite chair as long as I want
___2 Pain prevents me from sitting more than 1 hour
___4 Pain prevents me from sitting more than 10 minutes
___5 I avoid sitting because I have increased immediate pain

MCWHORTER CHIROPRACTIC OFFICE POLICY REGARDING HEALTH INSURANCE PAYMENTS

As a courtesy, we file insurance claims with your primary insurance company at no cost to you on your behalf. Our office will do everything possible to maximize your insurance benefits, but ***you are ultimately responsible for your account balance that is not paid by your insurance company*** within 60 days of receipt of a statement, regardless of the reason for nonpayment. After six billing cycles, all outstanding unpaid balances will be turned over to a collection bureau if we have not had any contact from you regarding the account.

We are aware there will be occasions when you may not be able to attend your appointment. **Please call within 24 hours of your scheduled appointment to cancel or reschedule if you are not able to attend your appointment.** After two missed appointments for which you didn't contact our office, there may be a missed appointment charge of $40.00 applied to your account. You will be responsible for payment of this charge

______________ (Initial Here)

In order to expedite the payment of your claims, please promptly provide your insurance company with any information they may request from you. This includes information such as accident details, verification of student status, or other insurance coverage. If requested information is not provided by you to your insurance company then they will not process your claim and deny payment at which time the balance will become your responsibility. Insurance networks continuously change and we cannot guarantee that we will be in network at any given time. We will do our best to have the most current information; however changes occur throughout the year, and we may not receive prior notice of these changes.

Please do not hesitate to ask us questions about our office policies. We want you to be comfortable in dealing with these matters, and we urge you to consult with us if you have any questions regarding our services or fees.

Our office will make every effort to verify your insurance benefits. Unfortunately, it is common for insurance companies to pay differently than quoted. If you have any questions regarding your insurance benefits, or feel that the information provided to our office is incorrect, we ask that you contact your employer or your insurance company directly regarding the specifics and details of your insurance plan.

Copays are to be paid at the time of service.

BY SIGNING BELOW, I AFFIRM THAT I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT, AND I AGREE TO PAY IN ACCORDANCE WITH THIS OFFICE INSURANCE POLICY. I ACCEPT THIS ATTENDING CHIROPRACTOR'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY TO THE TRUTH OF ALL INFORMATION PROVIDED.

Signature ____ Date____

Parent/Guardian (If patient is a minor) ____

McWhorter Chiropractic Informed Consent

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before beginning treatment. Although spinal and extremity manipulation/adjusting are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising – I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising with the first few treatments.
Dizziness – Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury – I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc disease, or other abnormality is detected, this office will proceed with extra caution.
Stroke – Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burn – Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment, and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and other such persons of the doctor's choosing.

ALTERNATIVE TREATMENTS ARE AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over the counter medications, exercises, and possible surgeries.
Medications – Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence and may have to be continued indefinitely. Some medication may involve serious risks.
Rest/Exercise – It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve or joint tissues.
Surgery – Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain, or reaction to anesthesia and prolonged recovery.
Non-treatment – I understand that the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely. I give my consent to the performance of conservative, non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient Signature: ____ Date: __________________________________

Guardian Signature: ____ Date: __________________________________
(For minor patient)

MCWHORTER CHIROPRACTIC - NOTICE OF PRIVACY PRACTICES

Jeremy McWhorter, D. C., 1600 Scottsville Rd, Suite 202, Bowling Green, KY 42104 Phone: 270-904-4111

Our practice is dedicated to maintain the privacy of your health information. We are required by federal and state laws to provide you with this Notice of Privacy Practices and to inform you of your rights, and our obligations, concerning your health information. We are required by law to follow the privacy practices described below while this notice is in effect. This notice is effective as of June 15, 2009 and will remain in effect until we replace it.

CHANGES TO NOTICE: We reserve the right to change this notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this notice to reflect the changes, and make the revised notice available to you on request. Any changes we make to our privacy practices and/or this notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our notice at any time. For more information about or for additional copies of this notice, please contact us using the information provided above.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. Treatment, Payment, Healthcare Operations: You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows**: Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. **Payment**: We may use and disclose your health information to obtain payment for services we provide to you. **Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. Authorizations: You may specifically authorize us to use your health information for any purpose to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving such authorization from you in writing, we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this notice.

C. Disclosures to Family and Personal Representatives: We must disclose your health information to you, as described in the Patient Rights section of this notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity, or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. Marketing: We will not use your health information for marketing communications without your written authorization.

E. Uses or Disclosures Required by Law: We may use, or disclose, your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.

F. Patient and Third Party Protection: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. Appointment Reminders: We may use your health information to provide you with appointment reminders, such as voicemail messages, text messages, emails, postcards, or letters.

H. Law Enforcement/National Security: Under certain circumstances, we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances, we may also disclose health information relating to inmates or patients to correctional institutions, or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings, and law enforcement inquiries as permitted by law, and to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.

PATIENT RIGHTS:

A. Access to Records: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information provided. You may request that we provide copies in a format other than photocopies, and we will use the format you request if it is readily available. Our practice shall provide one copy to you upon receipt of your written request. A copy fee, not to exceed $1.00 per page, will be charged for each additional copy requested. We may also charge postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost based fee for providing your health information in that format. If you prefer, we will prepare a summary, or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice if you are interested in receiving a summary of your information instead of copies.

B. Accounting Of Certain Disclosures: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and other activities authorized by you, for the last six years, but not before June 15, 2009. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. Restrictions and Alternative Communications: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment, and healthcare operations purposes. Depending on the circumstances of your request, we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than your home).

D. Amendments to Records: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. Electronic Notices: If you receive this notice on our website or by email, you are entitled to receive a written copy upon request.

QUESTIONS AND COMPLAINTS

If you want additional information about our privacy practices or have questions or concerns, please contact our office. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information provided. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, or with the U.S. Department of Health and Human Services. Please direct any questions or complaints to the information provided at the beginning of this notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of McWhorter Chiropractic, LLC, which describes the policies and procedures regarding the use and disclosure of my protected health information created, received, or maintained by the Practice.

______________________________	______________________________	______________________
Signature	**Guardian Signature**	**Date**

MCWHORTER CHIROPRACTIC
Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:___________________________ **Last Name**:___________________________

Email address: ____@_______________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Check one):** ___Male ___ Female **Preferred Language:** _________________

Smoking Status (Check one): ___Every Day Smoker ___ Occasional Smoker ___ Former Smoker ___ Never Smoked

CMS requires providers to report both race and ethnicity

Race (Check one): ___ American Indian or Alaska Native ___ Asian ___ Black or African American

___White (Caucasian) ___ Native Hawaiian or Pacific Islander ___ Other ___ I Decline to Answer

Ethnicity (Check one): ___Hispanic or Latino ___ Not Hispanic or Latino ___ I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:_________________

For office use only

Height: _________ Weight:_____________ Blood Pressure:______ /______

In compliance with Medicare requirements for the government EHR incentive program.