FOWLER CHIROPRACTIC PATIENT CASE HISTORY

Name: ______________________________________ Date: ______________________

Address: ____

City: _______________ State: ________ Zip: ___________ Date of Birth:___________

Telephone: (H) ______________ (Cell) ________________ (W) __________________

Email: _________________________________ Occupation: _______________________

Gender: Male Female Circle if you are Married Single Widowed Divorced

Where are you Employed? _____________________ Referred By: _________________

Person Responsible for this Account: __________________ Health Plan: ____________

Subscribers Name: _____________________ ID# ______________ GRP# __________

Surgeries:

1.____ Date: ________________________

2.____ Date: ________________________

Circle Any **Allergies:**

Animals Bees Chocolate Dairy Dust Eggs Latex Molds Ragweed/Pollen Shellfish

Seasonal Allergies Soaps Wheat X-Ray Dye Other: _____________________________

Circle Any **Allergies to Medicine:**

Advil Amoxycillin Codeine Demerol Erythromycin Hydrocodone Morphine Penicillin
Percocet Sulfa Tylenol Vicodin Other: ____________________________________

Current Medication:

Name	**Reason**
1. ___________________________________	________________________________
2. ___________________________________	________________________________
3. ___________________________________	________________________________
4. ___________________________________	________________________________
5. ___________________________________	________________________________

Patient Health Questionnaire

Patient Name: ________________________________ Date: ______________

Please check if you have ever had a symptom listed below.

Past	Present		Past	Present	
☐	☐	Neck Pain			Shoulder Pain L__R ___
		Upper Back			Lower Back L___ R ___
		Jaw L__ R___			Hip/Leg L____ R____
		Dizziness			Ringing in Ears
		Sciatica L__R___			Depression
		Arm L___ R____			Elbow L____R____
		Hand L___R___			Headaches
		Arthritis			Asthma
		Broken Bones			Chest Pain
		Diabetes			Epilepsy
		Eye/Vision			Fainting
		Fatigue			Joint Stiffness
		High Blood Pressure			Knee L__ R___
		Heart Problems			Multiple Sclerosis
		RA			Neurological
		Pacemaker			Parkinson's
		Polio			Prostate Problems
		Spinal Cord Injury			Sprain/Strain
		Stroke/Heart Attack			Other______________

HISTORY OF PRESENT ILLNESS

Major Complaint ____________________
____
Date Problem Began ____/____/_____
How? ______________________________
____

Secondary Complaint (if applicable)
____
Date Problem Began ____/____/_____
How? ______________________________
____

How is your condition changing? Better Worse Same Past/Previous Condition? Y N

Main reason for consulting the office:
- ▢ Become pain free
- ▢ Explanation of my condition
- ▢ Learn how to care for my condition
- ▢ Reduce symptoms
- ▢ Resume normal activity level

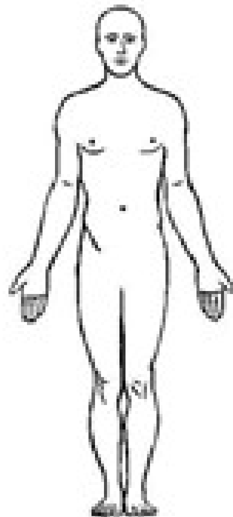
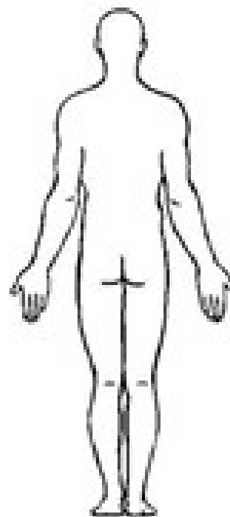
Describe nature of symptoms
▢ Sharp ▢ Dull ▢ Tight ▢ Numb
▢ Burning ▢ Shooting ▢ Tingling
▢ Stabbing ▢ Throbbing
▢ Radiating Pain
Other _________________________

Rate your pain on a scale of 1 to 10 (0= No pain and 10= Excruciating Pain).
▢1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8 ▢9 ▢10 Mild Moderate Severe

How often do you experience your symptoms? (Circle One)
Constantly (80-100%) Frequently (25-80%) Occasionally (0-25%)

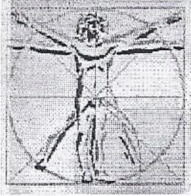
What activities aggravate your condition? (working, exercise, etc.): _________________

What makes your pain better? (ice, heat, massage, etc.): _________________________

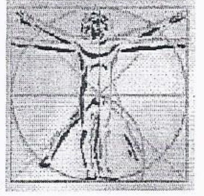



____________________________________ Signature

________________________ Date



Fowler Chiropractic
Dr. Monica L Fowler D.C.



7455 W Twin Peaks Rd. Ste 111 Tucson, AZ 85743

Office: 520-579-7906 Fax: 520-579-7912

Terms of Acceptance/Informed consent to Chiropractic Adjustments and Care

It is important for you, the patient, to know the difference between chiropractic care and the practice of medicine. Both may be important to your health, but for different reasons. The practice of medicine involves the diagnosis and treatment of symptoms and disease using medications, surgery, and radiation. The practice of chiropractic involves location and correction of spinal subluxations. Subluxations are misalignments in the spinal column, which cause interference to the quality and quantity of nerve flow from the brain to cells, tissues, and organs. Subluxations may or may not show immediate symptoms. The focus of the chiropractor is not on the treatment of symptoms or pain, but to adjust or re-align the spine to remove nerve interference, to allow the body to heal itself and function properly. Chiropractic care is not meant to replace medical care, so you, the patient, should get a second opinion if you have any concern to the nature of your illness or injury.

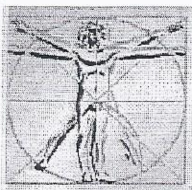
I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including but not limited to: examination, x-rays, and physiotherapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Monica Fowler and/or the other licensed doctors of chiropractic who now or will in the future treat me while employed by, working or associated with, or serving as a back-up/fill-in for Dr. Monica Fowler at the office listed above or any other office.

I understand and have had the opportunity to discuss with Dr. Monica Fowler and/or with office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: sprains, strains, dislocations, fractures, disc herniation/rupture, and strokes. I do not expect the doctor to be able to anticipate or explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure that she feels at the time, based on the facts known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above procedures. I intend for this consent to cover the entire course of chiropractic care for my present condition and for any future condition or conditions for which I seek treatment.

______________________ Patient Name (Print)	______________________ Date
______________________ Patient Signature	______________________ Authorized Provider Representative
______________________ Guardian's Name (Print)	______________________ Guardian's Signature & Relationship



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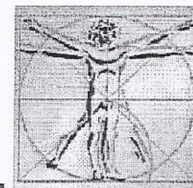

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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We reserve the right to change our privacy practices. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment of by mail. Please feel free to call us any time for a copy of our privacy practices.

Your Right to Limit Uses or Disclosures

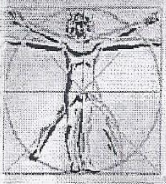
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restriction. However, if we agree with your restriction, the restriction is binding on us.

Your Right to Revoke Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request to revoke if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of you claims.

I have read your consent policy and agree to the terms. I am also acknowledging that I have received a copy of this authorization.

______________________________	______________________________
Patient Name (Print)	Date
______________________________	______________________________
Patient Signature	Authorized Provider Representative
______________________________	______________________________
Guardian's Name (Print)	Guardian's Signature & Relationship



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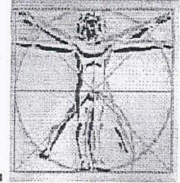

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest of you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

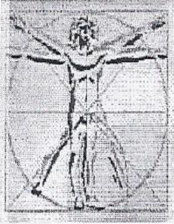
Information that we use or disclose based on the authorization you are giving us may be subject to re-disclose by anyone who has access to the reminder or other information and my no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _________. This authorization will expire seven years after the date on which you last received services from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this notice.

______________________________	______________________________
Patient Name (Print)	Date
______________________________	______________________________
Patient Signature	Authorized Provider Representative
______________________________	______________________________
Guardian's Name (Print)	Guardian's Signature & Relationship



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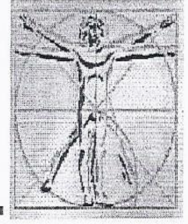

Examinations and Re-examinations/Additional Charges/Insurance Disclaimer

Per our office policy and insurance protocol, every patient is required to have an initial examination on the first visit with Dr. Fowler **before** they can receive treatment. Per office policy and insurance protocol, if a patient has been absent from care for six (6) months or more, we are **required** to perform a re-examination on the patient on the first visit upon their return **before** they are treated, no exceptions.

Self-pay patients: those who do not have insurance or who wish not to file insurance, payment is due upon services rendered. However, if in the future you wish our office to file insurance on your behalf or you gain insurance coverage, the following guidelines, policies, protocols and procedures will apply.

Those who wish to file insurance: as a courtesy to you we will file insurance on your behalf; however **benefits are not a guarantee of payment and/or coverage.** Due to constant insurance changes, high co-pays or deductibles there may be times our self-pay option may benefit you therefore we will give you the option to submit services deemed necessary by Dr. Fowler to your insurance company or you can pay the self-pay price through our office. If you chose to have insurance filed and your insurance does not cover, you will be responsible for the amount stated by the insurance company; it is at this time we **cannot** offer the discounted self-pay price for the date of service already filed.

Our office provides many services and products that many insurance companies do not cover. These services include but are not limited to: initial examinations, re-examinations, x-rays, ice packs, supportive bracing, supplements, physical therapies, massage, etc.

Examinations and Re-examinations/Additional Charges/Insurance Disclaimer Continued

Upon insurance verification of benefits, it is our job to inform you about your specific insurance company and policy coverage. We strive to do so as accurately as possible. You must also understand **benefits are not a guarantee of payment and/or coverage** and once insurance is filed on your behalf, it cannot be undone or discounted in any way and you will then be responsible for any charges filed to insurance.

As a courtesy to you, Fowler Chiropractic will file insurance on your behalf; however **benefits are not a guarantee of payment and /or coverage** and if for any reason your insurance company denies or fails to pay the claim, you will be financially responsible.

Once insurance is filed, we will continue to file until we are told otherwise by you or until coverage is terminated, whichever comes first. It is against our policy to file insurance for some dates of service and not others.

If coverage is terminated during the course of your care and you fail to notify us, you will be financially responsible for any charges denied by insurance.

If at any point your insurance has changed, it is your responsibility to make us aware of all changes prior to your visit/treatment.

I___________________________, a patient being treated by Dr. Monica Fowler of Fowler Chiropractic, do hereby acknowledge that a certain portion of my care may not be covered by my insurance company under the terms of my insurance provider or policy.

I ___________________________, acknowledge an examination or re-examination must be done prior to treatment rendered by Dr. Fowler

I____________________________, acknowledge that I have reviewed my options presented by the staff of Fowler Chiropractic and understand that I will be responsible for non-covered services which include but are not limited to deductibles, co-insurance and/or co-pays.

I____________________________, acknowledge payment is due at the time of service or upon verbal or printed notification.

This form will be filed in your patient file and will be effective immediately to any and all insurance claims billed on your behalf.

If you have any additional questions or wish to receive a copy, please notify the front desk staff.

_____________________________ _____________________________
Patient/Guardian Signature Date

_____________________________ _____________________________
Staff Member Print Staff Member Signature

FOWLER CHIROPRACTIC

7455 W. TWIN PEAKS STE 111

TUCSON, AZ 85743

HIPPA requires us to acquire detailed information from our patients. HIPPA requires for all new patients to have a picture on file; please not your picture will be taken for office purposes only

First Name:______________________ Last Name:________________________

Height:__________________________ Weight:___________________________

Race:___________________________ Ethnicity:________________________

Blood Presure:____________________

Smoke: r YES NO FORMER NEVER

Were you referred by anyone? YES NO

Who can we thank for the referral? _______________________________________

______________________________ ______________________

Patient Signature Date

Fowler Chiropractic
Dr. Monica L Fowler D.C.

7455 W Twin Peaks Rd Ste 111 Tucson, AZ 85743

(520) 579-7906 Office (520) 579-7912 Fax

Insurance Disclaimer

I,____________________________, a patient being treated by Dr. Monica Fowler of Fowler Chiropractic, do hereby acknowledge that a certain portion of my care may not be covered by my insurance company under the terms of my Health Care Plan.

As a courtesy to you, Fowler Chiropractic will file insurance on your behalf; however benefits are not a guarantee of coverage and if for any reason your insurance company denies or fails to pay the claim, you will be financially responsible for the bill.

If at any point your insurance has changed, it is your responsibility to make us aware of all changes prior to your visit/treatment.

This form will be filed in your patient file and will be effective to any and all insurance claims billed on your behalf.

I,___________________________, acknowledge that I have reviewed my coverage options and understand that I will make financial arrangements with Fowler Chiropractic to pay for services that are not covered by my insurance, including deductibles, co-insurance and co-pays.

_____________________________ _____________________________

Patient/Guardian Signature Date

_____________________________ _____________________________

Staff Member Print Staff Member Signature

Fowler Chiropractic
Dr. Monica L Fowler D.C.

8245 N. Silverbell Rd Suite 159 Tucson, AZ 85743
(520) 579-7906 Office (520) 579-7912 Fax

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize **Fowler Chiropractic** to administer treatment as they so deem necessary to my child.

STUDENT NAME: ______________________________

PARENT NAME: ________________________________

PARENT SIGNATURE: ___________________________

WITNESS: _____________________________________

DATE: ____