HEALING HANDS
CHIROPRACTIC

Damien Rodulfo, D.C., C.C.S.P.

Patient Information

Full Name: ______________________________ Date: ____/____/____

Preferred Name: ______________________________ Date of Birth: ____/____/____

Street Address: ______________________________ □ Female □ Male

City: ______________________ State: ________ Zip Code: ________

Primary Phone: ______________________ Type (Please Circle): Home Cell Work

Secondary Phone: ______________________ Type (Please Circle): Home Cell Work

Email Address: ______________________________

Emergency Contact: ______________________ Phone: ______________

Are you current or retired military personnel or a current first responder (Fire, Law Enforcement, EMS)? □ Yes □ No

Referral Information

How did you hear about our office? Please circle one of the following, and name the source in the space provided.

Physician Current Patient Attorney Family/Friend Crossfit/Gym Health Fair/Race

Google Yelp Other Internet Source

____

Consent for Treatment

Assignment and Release: By signing below, I authorize Healing Hands Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Healing Hands Chiropractic, and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance of any test or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

Signature: ______________________________ Date: ____/____/____

Name: ____

Please describe the reason for your visit: ____

____

____

Date symptoms began: ______/______/______ **Date of most recent flare-up:** ______/______/______

If this is an injury, how did the injury occur? ____

Symptom frequency (circle one): 25% or less 26%-50% 51%-75% 76%-100% **Of The** (circle one) Day Week Month

Symptom Timing (circle one of the following and indicate same, better, or worse)

Same all day Better/Worse in the morning Better/Worse at midday

Better/Worse at end of the day Better/Worse at night

Describe your pain or discomfort. Please select all that apply.

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

Describe which activities worsen your pain or discomfort. Please select all that apply.

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Lying Face Up	Driving
Typing	Scooping	House Chores	Exercise	Lying Face Down	Stair Stepping

Describe which activities relieve your pain or discomfort. Please select all that apply.

Sitting	Standing	Lying	Knees Bent Up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Ibuprofen	Medication	Rest	Stretching/Exercise	Adjustments

Where applicable, specify the approximate date of your most recent exams (month/day):

Physical Exam: ______/______ Dental X-Ray: ______/______

Spinal X-Ray: ______/______ CT Scan: ______/______

MRI: ______/______ Other Scans or X-Rays: ______/______

Name: ______________________________

Please check the box if you have had any of these conditions:

◯ AIDS/HIV	◯ Cancer	◯ High Cholesterol	◯ Parkinson's Disease
◯ Alcoholism	◯ Chest Pain	◯ Implant	◯ Pinched Nerve
◯ Allergy Shots	◯ Depression	◯ Kidney Disease	◯ Pneumothorax
◯ Anemia	◯ Diabetes	◯ Liver Damage	◯ Polio
◯ Appendicitis	◯ Digestive Problems	◯ Loss of Balance	◯ Prostate Problems
◯ Arthritis	◯ Dizziness	◯ Lung Problems	◯ Rheumatoid Arthritis
◯ Asthma	◯ Epilepsy	◯ Migraine Headaches	◯ Ringing in the Ears
◯ Bleeding Disorder	◯ Glaucoma	◯ Multiple Sclerosis	◯ Stroke
◯ Blurred Vision	◯ Heart Disease	◯ Osteoporosis	◯ Thyroid Problems
◯ Breast Lump	◯ Hepatitis	◯ Pacemaker/Stimulator	◯ Tumors

◯ Other: ______________________________

Current Medical Doctors/Alternative Doctors: ______________________________

Surgeries: ______________________________

Illnesses/Injuries/Hospitalizations: ______________________________

Medications: ______________________________

Vitamins/Supplements: ______________________________

Allergies: ______________________________

Typical Foods Eaten: ______________________________

Are you pregnant? ◯ Yes ◯ No Due Date: ______________

Tobacco: ◯ Cigarettes ◯ Cigars ◯ Pipe ◯ Smokeless **How often?** ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

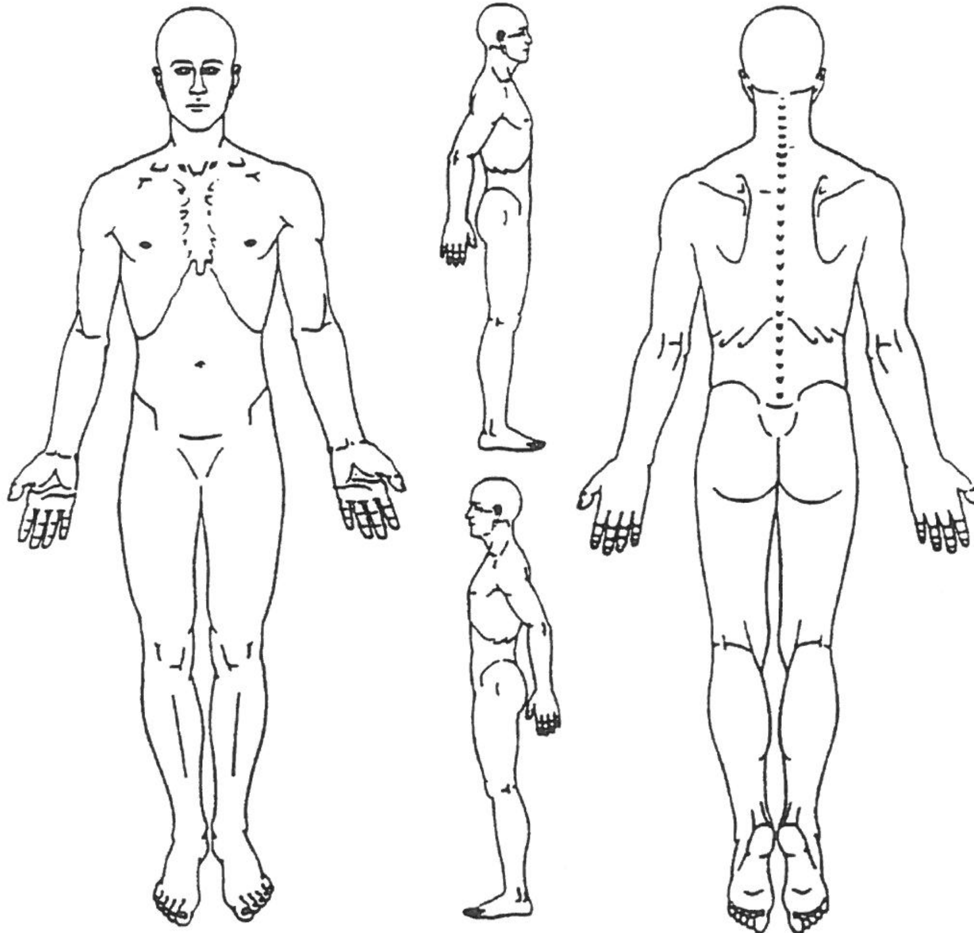
Alcohol: consumption occurs ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Recreational Drug Use: ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Exercise: ◯ Daily ◯ 2-3 times per week ◯ 1 time per week ◯ Never

Name: ____________________

Please indicate your areas of discomfort or pain by marking the affected body parts in the illustration.



Indicate the area name in the chart below. Rate your discomfort or pain associated with each selected area.

Ex.	(L) R Lower Back	0 1 2 3 4 5 6 (7) 8 9 10
1.	L R ____________	0 1 2 3 4 5 6 7 8 9 10
2.	L R ____________	0 1 2 3 4 5 6 7 8 9 10
3.	L R ____________	0 1 2 3 4 5 6 7 8 9 10
4.	L R ____________	0 1 2 3 4 5 6 7 8 9 10
5.	L R ____________	0 1 2 3 4 5 6 7 8 9 10

Healing Hands Chiropractic Automobile Accident Questionnaire

Full Name: ______________________________ Date: ____/____/____

Date of Accident: ____/____/____ Time of Accident: ____:____ AM/PM

Driver of Car: ______________________ Owner of Car: ______________________

Year/Make/Model of Car: ______________________________

Where you were seated at time of accident: ______________________________

Visibility at time of accident: Poor / Fair / Good / Other ______________________

Road conditions at time of accident: Icy / Rainy / Wet / Clear / Dark / Other ______________________

Where was your car struck?: Right / Left / Front / Rear / Side / Other ______________________

Type of accident: □Head on collision □Broad side collision □Rear end collision □Front Impact, rear ended car in front
□Non-collision ______________________________

What part of the car was damaged?: ______________________________

Describe what happened to you upon impact: ______________________________

____

Did you see that the accident was about to happen? □Yes □No

Did you brace for impact? □Yes □No

Were you wearing a seatbelt? □Yes □No

Does the car have headrests? □Yes □No

If yes, what part of your head was even with the top of the headrest? □bottom of head □middle of head □top of head

Was your car breaking? □Yes □No Was the other car breaking? □Yes □No

Was your car moving at the time of the accident? □Yes □No

If yes, how fast would you estimate you were travelling? ______________________

How fast would you estimate the other car was travelling? ______________________

What was the position of your head at the time of impact? □Head straight forward □Head turned left/right
□Head looking back □Other ______________________________

What was the position of your body at the time of impact? □Body straight in sitting position □Body rotated left/right
□Other ______________________________

At the time of the accident, recall what parts of your head or body hit what parts of the vehicle: ____________________

____

____

As a result of the accident were you □Dazed □Rendered unconscious □Other ____________________

Could you move all parts of your body? □Yes □No

If no, why not? ____________________

Were you able to get out of the car and walk unaided? □Yes □No

If no, why not? ____________________

Did you have any cuts or bruises from this accident? □Yes □No

If yes, where? ____________________

Describe how you felt immediately after the accident? ____________________

____

____

How did you feel later that □day □night? ____________________

How did you feel the next day(s)? ____________________

Check all symptoms apparent since the accident:

Headache	Numbness in fingers	Mid back pain	Loss of memory
Loss of taste	Loss of smell	Fatigue	Diarrhea
Cold feet	Cold hands	Pain behind eyes	Shortness of breath
Tension	Low back pain	Irritability	Nervousness
Chest pain	Constipation	Loss of balance	Sleeping Problems
Fainting	Dizziness	Numbness in toes	Other (Please List Below)
Cold sweats	Depression	Eyes sensitive to light	
Ringing/buzzing in ears	Anxious	Neck pain/stiffness	

Have you missed time from work? □Yes □No Work Status: □Full Time □Part Time □Unemployed

If you have missed time from work, how much time have you missed? ____________________

Did the accident occur during your work hours? □Yes □No

Did you seek medical help after the accident? □Yes □No

If yes, how did you get there? ____________________

Doctor/hospital/clinic seen: ____________________ Date: _______/_______/_______

What was done? ____

Were X-Rays taken? □Yes □No If so, of what body part? ___________________________

What treatment/prescriptions were given? □Bed rest □Brace □Adjustments □Medications □None of the above

What benefit(s) did you receive from treatment(s)? ___________________________

____

Date of last treatment: ______/______/______

Are any of your activities of daily living any different now compared to before the accident? □Yes □No

List anything you are unable to do: ___________________________

List anything that is painful to do: ___________________________

List anything that is difficult to do: ___________________________

Indicate on the diagram below how the accident happened and make any necessary comments or explanations:

Comments:___________________________

____

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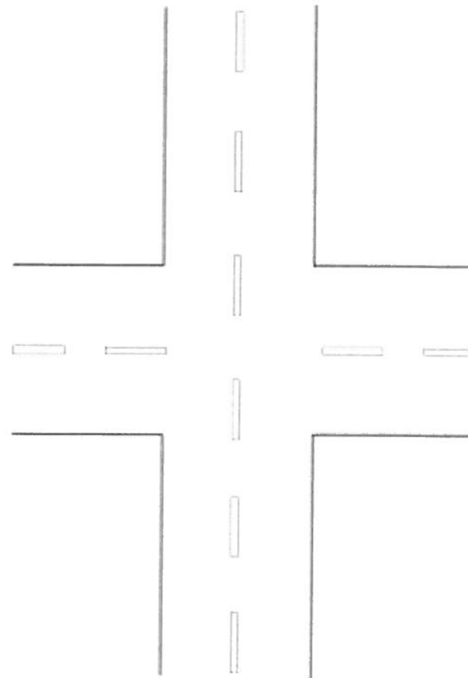

Do you have an attorney handing this case? □Yes □No

If so, who? (name and address) ___________________________

____

Insurance Information

Patient's personal car insurance company: ____

Policy #: ______________________ Insurance Phone #: (_______)_______-________

Insurance address: ____

City: ______________________________ State: ________ Zip Code: __________

Claim #: ______________ Adjustor's name/phone: ______________________________

Other party's car insurance company: ____

Patient's personal car insurance company: ____

Policy #: ______________________ Insurance Phone #: (_______)_______-________

Insurance address: ____

City: ______________________________ State: ________ Zip Code: __________

Claim #: ______________ Adjustor's name/phone: ______________________________

Major medical health insurance company: ____

Policy #: ______________________ Insurance Phone #: (_______)_______-________

Insurance address: ____

City: ______________________________ State: ________ Zip Code: __________

Assignment of Payment

My attorney and /or insurance carrier are hereby requested to pay direct to Healing Hands Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Healing Hands Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is additionally understood that I, the undersigned, agree to pay Healing Hands Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Print Full Name: ____

Signature: ______________________________________ Date: _____/_____/_____

Witness: ____

Election to Not File Health Insurance Claim

To whom it may concern:

Upon my inquiry, the staff of Healing Hands Chiropractic has advised me that the cost of my treatment may be covered in whole or in part by my own health insurance. The staff has informed me that if I file my own health insurance, I will be responsible for paying deductibles and co-payments, and these payments will be due as treatment is received. The staff has provided me with factual information regarding the various forms of reimbursement available to me and has answered my questions.

After giving due consideration to my options, I have decided **that I do not wish to file any claims on my health insurance**. I hereby instruct Healing Hands Chiropractic to refrain from sending bills and treatment records to my health insurance carrier or health benefit plan. I authorize the staff to send bills and treatment records only to potential sources of payment other than my health insurance.

I understand that the clinic will rely on my decision and render treatment based on the assumption that payment will be received from sources other than my health insurance. I will not be expected to pay deductibles and co-payments. I understand that if third party payors are billed, they will be billed at the clinic's usual rates rather than at the discounted rates that may apply to in-network providers.

I understand that contractual and statutory deadlines may prevent me from filing on my health insurance at a later date. **The decision I am making today not to file on my health insurance is irrevocable.**

I understand that I remain personally liable for the reasonable value of the treatment rendered to me by Healing Hands Chiropractic.

Patient Printed Name: ____

Signature: ____

Witness Printed Name: ____

Signature: ____

Date: ______ / ______ / ______

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CHIROPRACTIC

Damien Rodulfo, D.C., C.C.S.P.
2105-C W Cornwallis Dr.
Greensboro, NC 27408
(336) 235-4530
Fax (336) 235-0754

To any insurance company with coverage applicable to my claims and to any attorney representing us:

Assignment of Benefits

In consideration of the willingness of Healing Hands Chiropractic to treat me on credit without demand of payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Healing Hands Chiropractic any proceeds or compensation that I am or may be entitled to receive as a result of injuries that occurred on _______/_______/_______ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Healing Hands Chiropractic, from any disability benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise by payable to me, such as are due or may become due to Healing Hands Chiropractic for its services rendered.

I appoint Healing Hands Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named as payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Healing Hands Chiropractic.

I authorize Healing Hands Chiropractic to release any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries or prior medical history as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Healing Hands Chiropractic for services rendered, including any balance remaining after the application of insurance payment and settlement or judgment proceeds. If Healing Hands Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Healing Hands Chiropractic for its costs of recovery, including reasonable attorney's fees.

Patient's Full Name ____

Patient's Signature ______________________________________ Date ______/______/______

Parent or Legal Guardian __________________________________ Date ______/______/______

Witness ____ Date ______/______/______

Notice of Lien

Pursuant to N.C.G.S. 44-49 & 44-50, Healing Hands Chiropractic hereby asserts and gives notice of a lien upon any sums recovery in damages for personal injury in any civil action and also upon all funds paid to above-names patient in compensation for or in settlement of injuries sustained, whether in litigation or otherwise. Healing Hands Chiropractic hereby requests that if its claims are not paid in full from the foregoing proceeds, a full disclosure and accounting proceeds be provided in conformity with N.C.G.S. 44-50.1. Healing Hands Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of accounting.

Authorizations and Releases

Name: ____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care of treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am a legal guardian of the child, and grant my consent for a treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

Initial: _______________

Consent to Perform and Interpret X-Rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient, and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree that any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial: _______________

Females: Consent to X-Ray During Pregnancy

This is to certify that I am or may be pregnant and that a doctor or certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis can be hazardous to a fetus.

Initial: _______________

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health care plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial: _______________

Financial Obligations

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where in my liability is limited by contract of State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney for collection, I shall pay fees, including, but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial: _______________

Signature: ____ Date: _______/_______/_______