T.A. Huffman, Inc. dba Huffman Chiropractic

Legal Name_____ Spouse or SO _____

Prefer to be called_____ Birthdate _____ Age_____

E-mail_____ Do you have Medicare? Y N

Mailing Address _____

_____

Phone number(s) _____ mobile home work

How did you hear about Huffman Chiropractic? _____

Huffman Chiropractic is a cash practice. Is your visit today due to an accident? Yes No
Is your visit today due to an injury at work? Yes No

What brings you to our office today?

Have you ever had this problem or pain before? Yes No If yes, when?

How was the last episode resolved?

When did your symptoms with the most recent episode first begin?

What do you think caused this situation?

What makes you feel better? What makes symptoms worse?

What is harder to do because of how you feel? Family Chores Sleep Hobbies Work Occupation_____

Are the symptoms: getting better staying the same getting worse

How do symptoms change over the course of the day (better in the morning or evening, for example).

What other treatments have you tried?

Have you had a bad chiropractic experience in the past?

T.A. Huffman, Inc. dba Huffman Chiropractic

What do you hope to get out of treatment today?

Have you ever broken a bone? Y N If yes, where?

Do you have any pins, plates, or implants in your body? Y N

Have you ever had cancer? Y N Had chemotherapy? Y N Had radiation? Y N

Do you bruise easily? Y N Are you on a blood thinner? Y N

What allergies do you have?_____

Who is your family doctor? _____
Last visit? Do you see any specialists? Y N

System review: Please circle any systems that cause you problems.
Blood/Blood vessels/Heart Breathing/Lungs Digestion

Eye Mouth/Teeth Ear/Nose/Throat/Sinuses Kidney/Bladder

Glands/Hormones Immune system Nervous System

Mental health Skin/Hair/Nails Bones/tendons/ligaments

Muscles Joints Genitals

Do you have:

Y N Problems with recurring headaches?
Y N Pain that wakes you from a sound sleep?
Y N Unusual bleeding or discharge?
Y N Any change in bowel or bladder habits/constipation/diarrhea?
Y N An obvious change in a wart or mole?
Y N A sore that will not heal?
Y N Are you right-handed?
Y N A thickening or lump in the breast or elsewhere?
Y N A nagging cough or hoarseness?
Y N A drooping eyelid or change in your pupils?
Y N Slurred speech or difficulty speaking?
Y N Blood in your urine, stool or sputum?
Y N Night sweats?
Y N A recent episode of losing weight without trying?
Y N Numbness on one side of your face or body?
Y N Double vision, a loss of sight in one eye, visual disturbances, rapid eye movement?

T.A. Huffman, Inc. dba Huffman Chiropractic

Have you ever been diagnosed with a particular condition or disease? Please circle or list any diagnoses.

high blood pressure diabetes stroke aneurism COVID 19

Down syndrome arthritis TB lupus anemia epilepsy

depression anxiety heart disease

Please list any diseases that run in your family:

L=Living D=Deceased (Please list approximate age & reason if deceased.)
Please list any health problems for these relatives. Include high blood pressure, heart attack or cardiac issues, emphysema, seizures, diabetes, asthma, stroke, thyroid disease, circulation problems, cancer.

Mom L D Maternal Grandma L D Maternal Grandpa L D

Dad L D Paternal Grandma L D Paternal Grandpa L D

Siblings: Children:

List medications, herbs, supplements, and over the counter medications that you take.

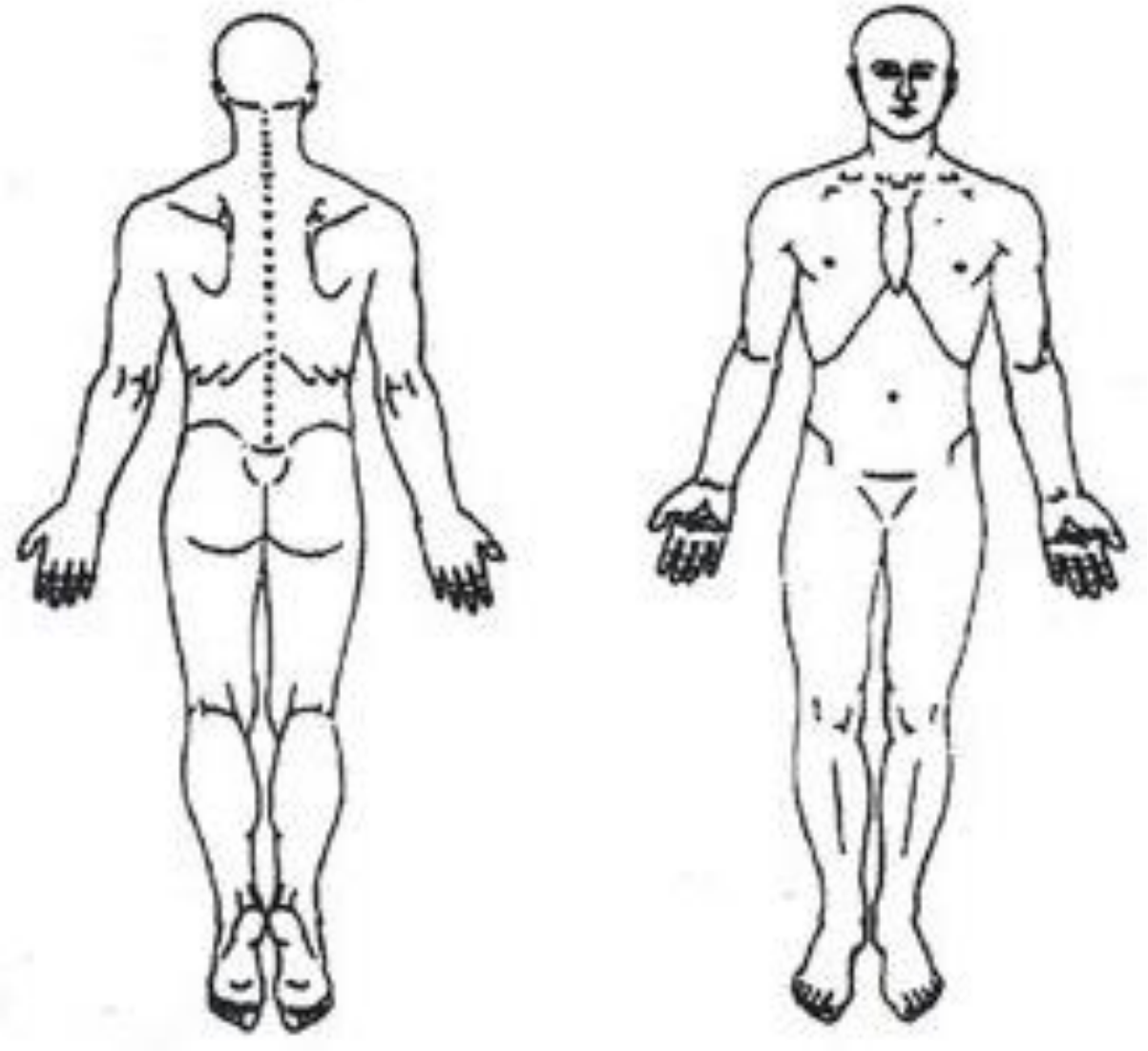
What surgeries have you had? Please list approximate year with each.

Do you drink alcohol? Y N
Do you smoke or vape? Y N
Do you wear your seatbelt? Y N
Do you use marijuana, hemp, CBD, or recreational drugs? Y N
Are you safe in your home? Y N

Please list any other diseases, experiences, conditions, details, or information that we have not already requested which would help us give you the best care possible.

T.A. Huffman, Inc. dba Huffman Chiropractic

Please mark on the diagram where you are experiencing symptoms. If you have symptoms in more than one location, please list them by priority (#1, #2, #3). Please also rate each location as 0 (no pain) to 10 (worst pain you can imagine).



T.A. Huffman, Inc. dba Huffman Chiropractic

Please print this page and bring it with you to your appointment.

Do not initial or sign this form until you have spoken to the doctor.

_____I request services from T.A Huffman Inc., dba Huffman Chiropractic.

_____I am of sound mind and legally permitted to sign for my own care or the care of the minor who I am presenting to Huffman Chiropractic for care.

_____All of the information supplied by me on these forms is true and accurate to the best of my knowledge at the time I provided it. I have not intentionally omitted any information.

_____I acknowledge that I have read or had an opportunity to read a copy of Huffman Chiropractic's Notice of Privacy Practices.

_____The benefits, risks, and alternatives associated with chiropractic care have been explained to me. I have been given the opportunity to ask questions and to clarify anything I did not understand.

_____I understand that my pain may increase and that chiropractic care may not solve my problem(s). I have been made aware that there is a risk of suffering a variety of side effects with chiropractic adjustments including common ones like soreness and dizziness and rarer ones like cerebrovascular accident (stroke).

_____I have read and freely signed a copy of the Huffman Chiropractic financial agreement. I understand that **I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES** associated with my care. I understand that Huffman Chiropractic will collect all fees DIRECTLY FROM ME in the form of cash, check, or money order at the time of service.

Huffman Chiropractic DOES NOT PARTICIPATE IN ANY INURANCE PLAN (although you are welcome to request a receipt or superbill and try to submit treatment costs yourself).

Huffman Chiropractic does not accept credit or debit cards at this time.

I agree to each term and condition above as evidenced by my initials before each statement.

_____ _____

Printed name Signature

_____ _____

Witness Date

T.A. Huffman, Inc. dba Huffman Chiropractic

Financial Agreement

The patient receiving our care pays our fees. This helps avoid disputes or pressure to compromise your care from insurance companies and other third parties. *If requested,* we will supply (at no cost) you with a superbill containing the information your third party will need to process your claim. If you have health insurance, an HMO, PPO, depend on Medicare, were injured on the job, in an automobile accident or some other personal injury, please feel free to discuss your options with us. We accept **cash, checks or money orders only**, no credit or debit cards.

First Visit On your first visit you will meet the doctor to discuss your current health situation and to see if you are a good candidate for chiropractic care. This consultation, which lasts about 15 minutes, is free. If we accept you as a patient, we will conduct a thorough examination and a deeper evaluation of your medical history to help us identify the likely cause(s) of your problem and helps us to formulate a treatment plan that is right for you. It takes about one hour to complete this exam. The cost is between $50 and $250 based on your age, the complexity of your medical history, and time spent. The standard fee is $100.

We believe that you want to feel better as soon as possible so we prefer to adjust on your first visit. Some patients (those in accidents, who are of an advanced age or those having certain medical conditions) MAY require x-rays before we can safely adjust them. These patients will receive only soft tissue massage, acupressure, or similar treatments to comfort them until x-rays can be taken.

Many people seek chiropractic care to deal with occasional flare-ups of painful conditions and stop care after the acute stage has ended. Other patients prefer to work with the doctor on lifestyle changes even after their pain has passed. This preventative approach may require a longer treatment period initially, but clients choosing this route often find that they have improved overall health and are not as prone to future pain flare-ups. This is the care we recommend. Just as you brush your teeth daily or change the oil in your car, your body requires maintenance for peak performance. However, we are happy to treat all patients, whether they prefer responsive care or preventative care. We feel that how you manage your health is always your choice.

Regular visit At each appointment you will receive a chiropractic adjustment. In our office that means you will receive a combination of acupressure, energy medicine, deep tissue massage, myofascial release, reflexology, stretching, and a variety of chiropractic adjustment styles based on your individual needs.

We believe that soft tissue work and retraining muscle memory is necessary to achieve lasting results. Chiropractors who bill insurance may offer these muscle-related services at an additional cost or eliminate them altogether. We include them in the cost of an adjustment for our TOS clients. A standard adjustment takes about 20 minutes and costs $45.00.

Progress Examinations We may monitor your progress with periodic exams every 8-12 visits. If you have a new problem or injury, you may also be re-examined.

T.A. Huffman, Inc. dba Huffman Chiropractic

Financial Agreement Continued

These exams help both you and our office to document your health status and your recovery. We may modify your treatment plan based on your exam findings. The fee for the progress/re-exam is usually $25 for TOS patients.

Individual Consideration Contract **If there is financial hardship associated with receiving care** in our office, please let us know so that we may tailor a payment schedule for you. Everyone deserves to feel good and we want to help make it affordable for you.

☐ CONTRACT ATTACHED

Billing Outstanding balances will be billed monthly and are considered past due 10 days after the invoice date. We will pass along the fee of $35 our bank charges us for any returned checks. Balances due beyond 30 days will be assessed a $25 fee per month, plus any legal and/or collection fees.

Our Promise We believe in the power of chiropractic to help you heal and we stand behind the quality of the care we offer. We cannot guarantee your results, but we want you to be satisfied that we will do everything we can to help you. If after two (2) visits, you become unhappy with your decision to consult our office we will refund the money you have paid us, minus $100 of the new patient exam fee, and make other care recommendations. Most of the time the healing process will take longer, but even during this early stage of care the majority of patients see enough progress to want to complete their care plan.

Missed Appointments We try to be flexible and know that sometimes missing an appointment is unavoidable. However, these missed appointments mean other patients may have to wait for care. If missed appointments become too frequent, or do not have 24 hours of notice, we may ask you to pre-pay for your next appointment and understand that even if you miss your next appointment, we will keep your payment *as if you were seen*. This fee reimburses the office for the lost revenue missed appointments represent and does NOT become a prepayment for your next visit. We reserve the right to refuse treatment to anyone without reason. If you fail to show up for your new patient examination more than one time we will require pre-payment before we reschedule you, and you will not be eligible for the money-back guarantee.

AGREEMENT **I accept full financial responsibility for my care.** I instruct this office to deliver care that, in their judgment, can best help me in the maintenance and restoration of my health. This is the entire financial agreement between T.A. Huffman, Inc. dba Huffman Chiropractic and the patient below. I have read this agreement, understand it, and agree with its provisions.

_____ _____

Patient or responsible party signature Date

Our office does not participate in insurance of any kind. As required by law, we do not have a dual fee schedule. We maintain a published fee schedule for insurers who chose not to pay us the day services are rendered, and a deeply discounted one for those who pay TOS (at the time of service.)

T.A. Huffman, Inc. dba Huffman Chiropractic

PATIENT CONSENT
FOR USE AND/OR DICLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning me at a phone number provided by me (home, cell or other) and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Signature **Date**