## NEW PATIENT INFORMATION

WELCOME TO OUR OFFICE! PLEASE COMPLETE ALL QUESTIONS.

Patient Name: _____ Date of Birth: _____

Home Address:_____ Email: _____

City: _____State: _____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Social Security No: _____ Marital Status: M W S D Sex: M F

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Social Security: _____

Who is responsible for payment? _____ Self _____ Spouse _____Other:_____

Who may we thank for referring you? _____

### Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

### Heath Care Authorization Form

THE PATIENT IDENTIFIED ABOVE AUTHORIZED **WELLNESS ONE: SHEPPARD CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to **Wellness One: Sheppard Chiropractic** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

- By signing this form you are giving Wellness One: Sheppard Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Print Name of Patient _____ Date _____

Signature of Patient _____

# Worker's Compensation Questionnaire

Patient Name: _____ Date of birth: _____

**Employer Information**

Who was your employer at the time of injury? _____
Address: _____
Phone #: _____ Supervisor's name: _____
When did you report the injury? _____
Who did you report the injury to? _____
Did you fill out an accident report? ☐ Yes ☐ No Do you have a copy of report? ☐ Yes ☐ No
What is your occupation? _____
What type of work do you do? _____

**Attorney Information**

Have you retained an attorney? ☐ Yes ☐ No
Name of Attorney: _____
Attorney's address: _____
Attorney's Phone: _____

**Accident Information**

Date of Accident: _____ Time of day: _____ ☐ A.M. ☐ P.M.
Please explain in detail how your injury happened: _____
_____
_____
_____
_____
When did you feel pain? ☐ Immediately after accident ☐ later that day ☐ next day ☐ _____
Where did you feel pain? _____
Did you return to work? ☐ Yes ☐ No Date you returned to work: _____
How much time have you lost from work? _____
Did Employer send you to a doctor? ☐ Yes ☐ No Who: _____
Did you see a doctor on your own? ☐ Yes ☐ No Who: _____
What was the doctor's diagnosis? _____
What medications are you taking? _____
Do any other diseases or accidents affect your employment? _____
_____
In your work, do you have to favor any part of your body? _____
Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Have you ever injured this area before? ☐ Yes ☐ No If yes, when? _____
Have you ever had a worker's compensation claim before? ☐ Yes ☐ No If yes, when? _____
Since the injury, are your symptoms getting: ☐ Improving ☐ getting worse ☐ the same

Patient's Signature: _____ Date: _____

# Informed Consent to Chiropractic Treatment

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

**Unusual risks: I have had the following unusual risks explained to me.**

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

_____

**Printed Name** **Signature** **Date**

_____

**WITNESS: Printed Name** **Signature** **Date**

# WELLNESS ONE: SHEPPARD CHIROPRACTIC

(828) 324-4600
www.BecomeHealthier.com

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

## ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of WellnessOne of Hickory to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to WellnessOne any proceeds or compensation that I am or may become 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 WellnessOne, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums are as due or may become due to WellnessOne for its services rendered.

I appoint WellnessOne 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 payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with WellnessOne.

I authorize WellnessOne to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitated collection of proceeds under this assignment.

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

_____ _____

Print Name Date

_____ _____

Patient Signature Witness

_____

Parent or Guardian (if patient is a minor)

**Notice of Lien**

In pursuant to N.C.G.S. 44-49 and 44-50, WellnessOne of Hickory hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

WellnessOne of Hickory hereby request that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. WellnessOne of Hickory agrees to be bound to any confidentiality agreements regarding the contents of the accounting.

# Informed Consent to Chiropractic Treatment

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

**Unusual risks: I have had the following unusual risks explained to me.**

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

_____

**Printed Name** **Signature** **Date**

_____

**WITNESS: Printed Name** **Signature** **Date**

WELLNESS ONE: SHEPPARD CHIROPRACTIC
(828) 324-4600
www.BecomeHealthier.com

I would like to have your e-mail address to add you to my patient list for free newsletters, updates, upcoming lectures, and any promotions that we offer.

The e-mails are completely private and can be removed at any time. I only send 1 or 2 each month.

Thank you,

Dr. Sheppard

E-mail address: (print clearly) _____

# Informed Consent to Chiropractic Treatment

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

**Dr. Sheppard history:** If you have any fears or concerns, please speak with me directly. I personally have given well over 150,000 spinal adjustments to all ages. There has never been ANY incident of serious harm or injury. Chiropractic when done precisely is the safest form of healthcare.

**I have read the explanation above. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo the treatment and hereby give my full consent.**

*Signature:* _____ *Date:* _____

# *Advantage Radiology Service*

*(419) 269-2424 (844) 283-4163*

This form is for a third-party business, Advantage Radiology Service (ARS), that will review your x-rays and prepare a report of their findings. This office, Wellness One of Hickory, needs your permission to send your x-rays to this company for a thorough review. Their service is a complete and separate entity. Most insurances cover this charge. In the event that this fee is not covered, a small fee may be incurred.

We just need a signature.

## *X-RAY ASSIGNMENT AGREEMENT*

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, VA, and/or to my attorney in the case of a personal injury. In the event that I receive payment for these services, I agree to promptly remit payment to ARS.

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company attorney, and/or third part payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning their claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as describe above.

Signature: _____ Date: _____

## *FOR OFFICE USE ONLY*

Name: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ Sex: _____ Age: _____

# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient _____

Policy holder's Employer _____

Policy Holder's DOB _____

Claim/Group # _____

SS/ID # _____

I hereby instruct and direct the _____ Insurance Company
To pay by check made out and mailed directly to:

**Wellness One of Hickory**
**Richard Sheppard, D.C.**
**36 14th Ave NE Suite 101**
**Hickory, NC 28601**

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O

I direct you to pay the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any medical information, or otherwise, pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____

Signature of policyholder Date

_____

Signature of claimant, if different than policyholder

Wellness One of Hickory
Dr. Richard Sheppard, D.C.
36 14th Ave. NE # 101 * Hickory, NC 28601
(828) 324-4600

# HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handle appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payors in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to require restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, on this date _____, to hereby consent and acknowledge my agreement to the terms set forth in this HIPPA INFORMATION AND CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.