Lincoln Chiropractic, PC

108 Newbold St – Lincolnton, NC 28092

Dr. Damon C. Blackley, DC
Dr. Lori B. Blackley, DC

Phone: 704-735-8226
contactus@mylincolnchiropractic.com
www.mylincolnchiropractic.com

Patient Name _____**Date** _____**Account** _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____Cell Phone _____ Work Phone _____

Email Address _____

Sex: M F Marital Status: M S D W Date of Birth _____ SS# _____

Employer Name/Occupation _____

Spouse Name _____ How did you hear about our office? _____

Emergency Contact Name/ Phone _____

Have you ever been to a chiropractor before? If so, who and why?_____

WHAT BRINGS YOU TO OUR OFFICE TODAY?
Please provide as much detail as possible

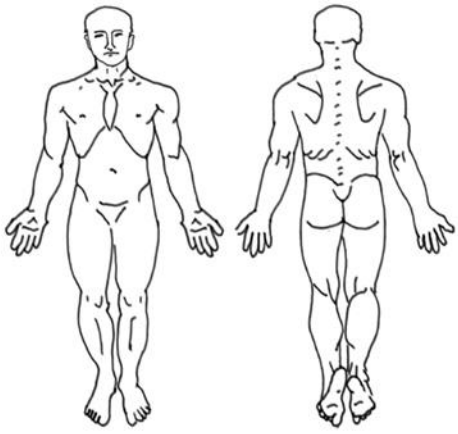
Primary Complaint:

_____

_____

_____

_____



Please mark areas of your complaint on the diagram:

PPP = Pain
TTT = Tingling
CCC = Cramping
NNN = Numbness
BBB = Burning
OOO = Other

It is usual and customary to pay for services as rendered unless otherwise arranged. I do hereby authorize Lincoln Chiropractic, PC to furnish my Insurance Co. with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regards to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him/her for chiropractic services rendered on me. I understand I am directed and fully responsible to said doctor for all medical treatment submitted by him for services rendered me. This agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctors interest, he/she will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts payable to said doctor for services rendered.

Patient Signature X_____ Date _____

Doctor Signature X _____ Date _____

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Height _____ Weight _____ Primary Physician _____

Do you smoke? □Y □N Cigarettes per day _____ Years smoke _____ Years quit _____

Do you consume alcohol? □Y □N Drinks per day _____

Do you exercise? □Y □N Exercise how often/type _____

Do you have a high stress level? □Y □N Reasons _____

List any current medications/vitamins _____

_____

Hobbies/Daily Activities_____

Please list all surgeries, injuries, accidents, falls, etc _____

_____

_____

FEMALE PATIENTS: Are you pregnant? _____ Date of last Menstrual Cycle _____

Please circle if you have had any of the following:

AIDS/HIV	Alcoholism	Anemia	Allergy Shots	Anorexia
Anorexia	Arthritis	Asthma	Bleeding Disorders	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependency
Chicken Pox	Diabetes	Disc Degeneration	Emphysema	Epilepsy
Epilepsy	Glaucoma	Goiter	Gonorrhea	Gout
Heart Attack	Heart Disease	Hepatitis	Hernia	Herpes
High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Measles
Migraine	Miscarriage	Mononucleosis	Multiple Sclerosis	Mumps
Osteoporosis	Pacemaker	Parkinson's Disease	Pinched Nerve	Pneumonia
Polio	Prostate Problem	Prosthesis	Psychiatric Care	Stroke
Rheumatic Fever	Scarlet Fever	Suicide Attempt	Thyroid Problems	Tonsilitis
Tuberculosis	Tumors/Growth	Typhoid Fever	Ulcers	Vascular Disease
Vaginal Infections	Venereal Disease	Whooping Cough	Rheumatoid Arthritis	

Please list if family members have had any of the above stated conditions or any other conditions that run in your family: _____

_____

_____

Patient Signature X_____ Date _____

Doctor Signature X _____ Date _____

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INFORMED CONSENT FOR EXAMINATION & TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic named above and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

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, fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations, and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions (s) for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Dr. Blackley has verbally reviewed this form with me and answered any questions to my satisfaction.

Patient Signature X_____ Date _____

Doctor Signature X _____ Date _____

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Consent for Use or Disclosure of Health Information

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.

Circumstances wherin we may have to use or disclose your health care information:

1) We may have to provide this 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.
2) We may also have to provide this information to another party if they are potentially responsible for the payment of your healthcare services, such as an insurance company or your attorney.
3) We may need to use your health information within our practice for quality control or for other operational purposes.

We reserve the right to amend and/or change our privacy (disclosure) policy with any changes being made retroactively and will be available for your review upon request.

Appointment Reminders and Health Care Information Authorization

Lincoln Chiropractic, PC may need to use your name, address, phone number and clinical records to contact you by phone or mail with appointment reminders, information about treatment alternatives, newsletters, or other health-related information. If this contact is made by phone and you are not home, a message will be left on your answering machine, with your significant other or with a family member (as identified). By signing this form, you are giving us authorization to contact you with these reminders and/or concerning other health or billing-related information

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 wish to place any restriction on the use or disclosure of your health information, please do so in writing. We are not bound by your restriction, but, if we agree to abide by your restrictions, then those restrictions are binding to us.

Your Right to Revoke Your Authorization

You may revoke your consent to this office, at any time. Any revocation must be in writing and will not affect any information provided in the normal management of your case or claim, when said health information was provided prior to your revocation request. If you were required to give your authorization, as a condition of obtaining insurance, then the insurance company may have a right to your health information, if they decide to contest or qualify any portion of your claim.

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

This notice is effective, when signed, and will expire seven (7) years after the date on which you last received service from us.

I authorize Lincoln Chiropractic, PC to use or disclose my health information in the manner described above and acknowledge that I have been offered a copy of this authorization.

I acknowledge receipt of a copy of the office NOTICE OF PATIENT PRIVACY POLICY.

Patient Name _____ **Parent/Legal Guardian Name** _____

Patient Signature _____ **Date** _____

Parent/Legal Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____