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# Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female Number of Children \_\_\_\_\_  
 Marital Status: Married Single Divorced Separated Other \_\_\_\_\_  
 Name of Spouse or Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Your Occupation \_\_\_\_\_ Your Employer: \_\_\_\_\_

We would like to make this as transparent an experience as possible. If you have any questions/concerns regarding your health care or finances please do not hesitate to ask!  
 Conditions we treat : Jaw, neck and back pain, numbness/tingling, arm, shoulder/elbow/wrist pain, hip/leg/knee/foot pain, breech birth presentation, pelvic floor dysfunction, incontinence, pelvic pain, prenatal/postnatal rehab, strength and conditioning.

How were you referred to our office: Doctor- Name? \_\_\_\_\_ Yellow Pages  
 Friend/Family Member - Name? \_\_\_\_\_ Location Other \_\_\_\_\_

Services you are interested in: Acupuncture Chiropractic Joint Release Therapy  
 Strength Training Pain Management Active Release Techniques Massage Therapy

Payment for Services will be by: Cash Check Credit Card # \_\_\_\_\_ Exp: \_\_\_\_\_  
 Health Insurance Automobile Insurance Worker's Compensation Claim# \_\_\_\_\_  
 Name of Insurance Co.: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
 Insured's Claim.#/Policy#: \_\_\_\_\_ Employer's Phone #: \_\_\_\_\_  
 Are you covered by more than one insurance company? Yes No Name \_\_\_\_\_  
 Phone # of Secondary Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

**MEDICAL/FAMILY HISTORY** S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fevers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions

Have you had previous chiropractic care? \_\_\_\_\_ Doctor \_\_\_\_\_ When \_\_\_\_\_  
 Primary Care Physician's name: \_\_\_\_\_ Office location: \_\_\_\_\_ Phone # \_\_\_\_\_  
 May we update your PCP regarding your progress at our office? \_\_\_\_\_  
 Have you been treated by a physician for any health condition in the last year?  Yes  No  
 Describe Condition \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

**SURGICAL HISTORY:**

1. \_\_\_\_\_ Date: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had a metal implant?  Yes  No Ever been gunshot?  Yes  No

ACCIDENT HISTORY :    Job Auto Other 1. \_\_\_\_\_ Date: \_\_\_\_\_  
                                 Job Auto Other 2. \_\_\_\_\_ Date: \_\_\_\_\_  
                                 Job Auto Other 3. \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**

Please Rate Your symptoms (1-10, with 1 being no pain and 10 unbearable pain)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**SYMPTOMS ARE WORSE IN**    MORNING    AFTERNOON    NIGHT

**SYMPTOMS DEVELOPED FROM:** JOB RELATED INJURY    AUTO ACCIDENT    OTHER    ACCIDENT  
ILLNESS    UNKNOWN CAUSE    GRADUAL ONSET    DATE OCCURRED: \_\_\_\_\_

**SYMPTOMS HAVE PERSISTED FOR** \_\_\_ HOUR(S) \_\_\_ DAY(S) \_\_\_ WEEK(S) \_\_\_ MONTH(S) \_\_\_ YEAR(S)

**SYMPTOMS/COMPLAINTS:**    COME & GO    ARE CONSTANT

**HAVE YOU EVER HAD THIS BEFORE:**    NO    YES    WHEN? \_\_\_\_\_

**IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?**

**NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):**  
\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS**    NO    YES    WHAT KIND?  
\_\_\_\_\_

**ARE YOU TAKING ANY MEDICATIONS**    NO    YES    WHAT KIND?  
\_\_\_\_\_

**ARE YOU PREGNANT** NO    YES    DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_  
DUE DATE: \_\_\_\_\_

**What makes the condition worse:**  
\_\_\_\_\_

**What makes the condition better:**  
\_\_\_\_\_

**Social History**

Tobacco usage	None	<input type="checkbox"/>	< 1 pack/day	<input type="checkbox"/>	1-2 packs/day	<input type="checkbox"/>	>2 packs/day	<input type="checkbox"/>
Alcohol usage	None	<input type="checkbox"/>	Light	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Heavy	<input type="checkbox"/>
Drug usage	None	<input type="checkbox"/>	Light	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Heavy	<input type="checkbox"/>
Exercise	Never	<input type="checkbox"/>	Seldom	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Regularly	<input type="checkbox"/>

**I hereby give permission to the doctor to release any information requested by my insurance company in the course of my examination and treatment.**

**I hereby authorize and direct my insurance benefits to be paid directly to this doctor's office. I understand that I am financially responsible for all non-covered services and/or expenses.**

**I hereby authorize employees of Hemmett Family Chiropractic to contact me via telephone or leave a message at my home phone in order to give me results of clinical tests and schedule or remind me of appointments.**

**Patient's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Hemmett Family Chiropractic & Massage



## **MISSED APPOINTMENT:**

Every patient is allowed one missed appointment. The second time a patient misses an appointment without notifying the office, they will be charged \$20. Any patient missing three appointments in a year will no longer be able to schedule in advance, but can continue to be seen in a walk-in basis.

## **TARDINESS:**

If a patient is more than 10 minutes late, they will need to be rescheduled and will count as a missed appointment.

## **CANCELLATION:**

Patients may cancel an appointment without any penalty as long as the notification is at least 2 hours prior to the appointment time. Any cancellation within 2 hours of the appointment time will count as a missed appointment.

I \_\_\_\_\_ understand Hemmett Family Chiropractic's policy on missed appointments, cancellations and tardiness. I agree to pay the \$20 fee as outlined above.

\_\_\_\_\_  
Patient's signature

Drs. Erik and Vicki Hemmett  
185 Tilley Drive  
South Burlington, VT 05403  
802-879-1703  
(fax) 802-863-9299



## OFFICE FINANCIAL POLICY

**INSURANCE:** As a courtesy to you, we will contact your insurance company to attempt to verify your coverage and bill your insurance company directly for our services. However, please remember that this is your insurance policy, and you are ultimately responsible for any charges that are required for your care that are not paid for by your insurance company. All co-pays and deductibles are due at the time of service. Your balance can not exceed \$100. Once your account exceeds \$150 or becomes 60 days past due, your credit card will *automatically* be charged for the full amount.

**MEDICARE:** You must pay in full for non-covered services at the time of each visit. Fees for exams, x-rays, physical therapy (electrical muscle stimulation, ultrasound), Active Release Technique, Acupuncture and supplements are NOT covered by Medicare. In addition, there is a chiropractic deductible for Medicare then only 80% coverage for chiropractic manipulations only. You will be responsible for the deductible, all non-covered services and 20% of each chiropractic manipulation. Your balance can not exceed \$100. Once your balance exceeds \$150 or becomes 60 days past due your credit card will be *automatically* charged the full amount.

**AUTO ACCIDENT/PERSONAL INJURY:** If you were involved in an automobile accident/ personal injury, you must complete an assignment for direct payment to our office. Before we can provide service, you must report the accident to your insurance company so a claim number can be assigned. We will bill your auto insurance medical pay or “Med-pay” benefit. Your auto insurance will be reimbursed for the payments it makes by the at-fault insurance company at the end of the case. Regardless of settlement, you are personally responsible for the entire balance.

**CASH:** If you do not have insurance coverage of any kind, you will be expected to pay for the services in full at each visit. We accept checks, Visa, MasterCard, Discover and even cash. Payment is due at time of service. Your balance can not exceed \$100. Once your balance exceeds \$150 or becomes 60 days past due your credit card will *automatically* be charged the full amount.

**Missed, Cancelled Appointments:** Time is valuable to everyone. Out of respect for other patients waiting to be seen, we ask that you call ahead if you wish to miss an appointment. Everyone will be allowed **one** missed appointment without calling, and then **each** additional occurrence will be charges a **\$20 no show fee**. See appointment policy form for details.

**I have read the policies of this office. I fully understand and agree with them. I hereby authorize and direct my insurance benefits to be paid directly to this doctor’s office. I authorize my credit card to be charged for my full account balance once it exceeds \$150 or becomes 60 days past due. If my account becomes 90 days past due, I understand that a 12% interest fee will be assessed. I also understand that if my account is sent by Hemmett Family Chiropractic & Massage to a collections agent, I will also be responsible for all the fees associated with collecting my delinquent account.**

Credit Card: Visa / MC / Discover# \_\_\_\_\_ Exp. Date \_\_\_\_\_ CV code \_\_\_\_\_

Patient’s Name: \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Drs. Erik and Vicki Hemmett  
185 Tilley Drive  
South Burlington, VT 05403  
802-879-1703

## 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 a copy of 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 care 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.

### Appointment Reminders, Voluntary Sign-in sheet, Health Information back-up procedures 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 to you. If this contact is made by phone and you are not at 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 by telephone and postcard.

Our office utilizes a sign-in sheet in order to keep track of who is in the office. Our office backs up all health information to an external hard drive and laptop that is secured off the premises.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment, or by mail. Please feel free to call us at any time for a copy of our privacy notices.

### 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 restrictions. However, if we agree with your restrictions, the restriction is binding on us.

### Your right to revoke your authorization

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 if we have already released your health information before we receive your request to revoke your 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 decide to contest any of your claims.

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 the date of your signature at the bottom. 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 authorization.**

\_\_\_\_\_  
Patient name, printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Authorized provider representative

\_\_\_\_\_  
Personal representative, printed

\_\_\_\_\_  
Personal representative, signature

## Privacy Notice Acknowledgment

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Back and Neck Center's *Notice of Privacy Practices for Protected Health Information*.

\_\_\_\_\_  
Patient Name, Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Rep

\_\_\_\_\_  
Personal Representative, Printed

\_\_\_\_\_  
Personal Representative, signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.