POLICY AND PATIENT FORM

1. **PAYMENT** is due at the time of service, unless other arrangements have been made.
2. An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore it is the responsibility of the patient to keep the account current.
3. Patients involved in **LITIGATION** (law suits) are, as others, responsible for their services at the clinic.
4. We reserve the right to **BILL FOR MISSED APPOINTMENTS.**
5. Personal cleanliness is requested due to the close interpersonal nature of this work.
7. **SMOKING IS PROHIBITED.**

PLEASE PRINT

Home Phone Number ______________

PATIENT NAME ______________ Work Phone Number ______________

Street/P.O. Box ______________ City/State/Zip ______________

Previous Address ______________

BIRTHDATE ______________ SOC. SEC. # ______________ Driver's License # ______________

AGE ______________ HEIGHT ______________ WEIGHT ______________

OCCUPATION ______________ EMPLOYER ______________

NAME OF SPOUSE ______________ Work Phone Number ______________

SPOUSE'S OCCUPATION ______________ EMPLOYER ______________

NAMES OF CHILDREN AT HOME/DATES OF BIRTH ______________

BY WHOM WERE YOU REFERRED? ______________ Yellow Pages

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE NOTIFY? ______________ PHONE ______________

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY SAME.

PATIENT SIGNATURE ______________

TODAY'S DATE ______________ WITNESS ______________

If the patient is a minor. Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

Guardian Signature ______________

IF YOU HAVE HEALTH INSURANCE, PLEASE FILL OUT BELOW

NAME OF INSURED (If patient is a dependent) ______________

EMPLOYER OF INSURED ______________

NAME OF INSURANCE POLICY ______________ POLICY NUMBER ______________

BILLING ADDRESS ______________ PHONE NUMBER ______________

AUTHORIZATION TO RELEASE INFORMATION: I, hereby, authorize Foster Clinic of Chiropractic to release any information acquired in the course of my treatment.

______ Signed: ______________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I, hereby, authorize the payment of medical benefits directly to Foster Clinic of Chiropractic.

Signed: ______________

DATE ______________

PLEASE PRINT — **SUBJECTIVE COMPLAINTS** — **PLEASE PRINT**

SUBJECTIVE COMPLAINTS

Explain WHEN and HOW it happened: ____

____

COMPLAINTS/SYMPTOMS: ☐ Come and go ☐ Came on gradually ☐ Came on suddenly

Symptoms have persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years

Symptoms developed from: ☐ A work-related injury ☐ An auto accident ☐ An injury other than at work or an auto accident

DESCRIBE COMPLAINTS: ***PLEASE BE SPECIFIC***

Involving Neck & Head: ____

Involving Mid-back/Shoulders/Arms & Hands: ____

Involving Low Back/Hips/Legs & Feet: ____

What activities make condition WORSE? ____

What activities make condition BETTER? ____

Have you ever had this condition/problem before: ☐ Yes ☐ No

If yes, when? ____

Give name(s) and address(es) of doctor(s) previously seen for the present complaint: ____

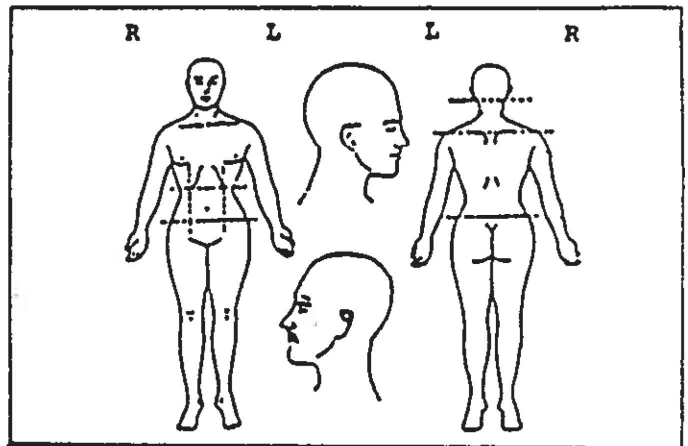
____

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES: *USE CODES:*
U - Unable P - Painful D- Difficult L - Limited N- Normal

- ____ Coughing or sneezing
- ____ Getting in or out of a car
- ____ Bending forward to brush teeth
- ____ Turning over in bed
- ____ Walking short distance
- ____ Standing for more than 1 hour
- ____ Sitting at a table
- ____ Lying on back
- ____ Lying flat on stomach
- ____ Lying on side with knees bent
- ____ Bending over forward
- ____ Climbing
- ____ Kneeling
- ____ Balancing
- ____ Dressing self
- ____ Sleeping
- ____ Stooping
- ____ Gripping
- ____ Pushing
- ____ Pulling
- ____ Reaching
- ____ Sexual Activity

Symptoms are BETTER in: ☐ AM ☐ Midday ☐ PM
Symptoms are WORSE in: ☐ AM ☐ Midday ☐ PM
☐ Symptoms do not change with time of day

SHADE AND CODE AREA(S) TO INDICATE LOCATION OF PAIN OF DISCOMFORT: *USE CODES:*
P - Pain N - Numbness S- Spasm T - Tenderness:



FAMILY HISTORY

		# Living Age	Health	# Deceased Age at death	Cause	Has any Blood relative ever had:	Please Circle no or yes	who
Father						Cancer	no yes	
Mother						Tuberculosis	no yes	
☐ Brother ☐ Sister	1.					Diabetes	no yes	
☐ Brother ☐ Sister	2.					Heart Trouble	no yes	
☐ Brother ☐ Sister	3.					High Blood Pressure	no yes	
☐ Brother ☐ Sister	4.					Stroke	no yes	
☐ Brother ☐ Sister	5.					Epilepsy	no yes	
Husband or Wife						Insanity	no yes	
☐ Son ☐ Daughter	1.					Suicide	no yes	
☐ Son ☐ Daughter	2.					Other		
☐ Son ☐ Daughter	3.							
☐ Son ☐ Daughter	4.							

PATIENT HISTORY

Have You Ever Had:

DATE: ____________

Reg. Measles	no	yes	Typhoid Fever	no	yes
Ger. Measles	no	yes	Influenza	no	yes
Mumps	no	yes	Pneumonia	no	yes
Whooping Cough	no	yes	Tuberculosis	no	yes
Diarrhea	no	yes	Scarlet Fever	no	yes
Chicken Pox	no	yes	Rheumatic Fever	no	yes
Small Pox	no	yes	Strep Throat	no	yes
Syphilis	no	yes	Polio	no	yes
Gonorrhea	no	yes	Meningitis	no	yes

Medications: List All Medications You Are Currently Taking:

LIST SURGERIES

Allergies:

Penicillin ....no yes

Sulfa Drugs ....no yes

Barbiturates ....no yes

Eggs ....no yes

Other Drugs ____________

PERSONAL HISTORY:

Place of birth ____________

States in which you lived ____________

Countries where you lived, or visited ____________

Current occupation ____________

Previous occupation ____________

Cigarettes packs per/day ____________

Cigars ☐ Pipe ☐

Alcohol consumption ____________

Type ____________ Quant. per week ____________

Coffee, cups per day ____ Tea, cups per day ____

Regualr exercise ☐ Yes Type

☐ No

PATIENT HISTORY

SYSTEMS REVIEW: Please circle if you have ever had...

M.	Frequent Headaches	no	yes
	Migrane Headaches	no	yes
E.	Double Vision	no	yes
	Blurred Vision	no	yes
	Spots Before Eyes	no	yes
	Blindness	no	yes
	Eye Pain	no	yes
	Glaucoma	no	yes
	Need for Glasses	no	yes
E.	Ear Infection	no	yes
	Ringing in Ears	no	yes
N.	Nose Bleeds	no	yes
	Discharge	no	yes
	Loss of Smell	no	yes
	Frequent Colds	no	yes
	Post Nasal Drip	no	yes
T.	Frequent Sore Throat	no	yes
	Chronic Hoarseness	no	yes
	Strep Throat	no	yes
PLUM.	Chronic Cough	no	yes
	Coughing Blood	no	yes
	Sputum Production	no	yes
	Shortness of Breath	no	yes
	Asthma	no	yes
CV.	Chest Pain	no	yes
	Heart Attack	no	yes
	Palpatations	no	yes
	Calf Pain	no	yes
	Heart Murmur	no	yes
	High Blood Pressure	no	yes
	Low Blood Pressure	no	yes
	Fainting Spells	no	yes
GI.	Peptic Ulcer	no	yes
	Recurrent Abdominal Pain	no	yes
	Black or Bloody Stools	no	yes
	Vomiting Blood	no	yes
	Vomiting	no	yes
	Change in Bowel Habits	no	yes
	Change In Stool Appearance	no	yes
	Constipation	no	yes
	Diarhea	no	yes
	Intestinal Parasites (worms)	no	yes
	Difficulty Swallowing	no	yes
	Frequent Heart Burn	no	yes
	Hiatus (Hiatal) Hernia	no	yes
	Gallstones	no	yes
	Hepatitis	no	yes
	Jaundice ("Yellow Jaundice")	no	yes
	Cirrhosis of Liver	no	yes
G.U.	Kidney or Bladder Infection	no	yes
	Pain or Burning on Urination	no	yes
	Pus in Urine	no	yes
	Blood in Urine	no	yes
	Urinary Frequency	no	yes
	Urinary Urgency	no	yes
	Urinating After Bedtime	no	yes
	Urinary Dribbling	no	yes
	Kidney or Bladder Stones	no	yes

MALE ONLY

Prostate Trouble	no	yes
Difficulty Initiating Stream	no	yes
Interrupted Stream	no	yes
Impotence	no	yes

FEMALE ONLY

Date of Last Period	no	yes
Duration of Period______Days		
Length of Cycle________Days		
No. of Pregnancies____________		
Excessive Flow Periods	no	yes
Bleeding Between Periods	no	yes
Frequent Periods	no	yes

MS.	Joint Pain	no	yes
	Tender, Swollen, Red or Hot Joints	no	yes
	Back Pain	no	yes
	Frequent Leg Cramps	no	yes
HEM.	Anemia	no	yes
	Treatment Date______________		
	Blood Transfusion	no	yes
	When________________		
	Why________________		
	#Units__________		
	Excessive Bleeding	no	yes
	Recurrent Nose Bleeds	no	yes
	Easily Bruised	no	yes
ONC.	Loss of Appetite	no	yes
	Unexplained Wt. Loss	no	yes
	Any Lump or Mass	no	yes
	Removed______________		
	When________________		
	Unusual Mole or Warts	no	yes
	Enlarged Lympe Nodes	no	yes
ENDO.	Recent Wt. Gain	no	yes
	Excessive Sweating	no	yes
	Diabetes (sugar in urine)	no	yes
	High Cholesterol	no	yes
N.P.	Stroke	no	yes
	Paralysis or Weaknesses	no	yes
	Loss of Sensation	no	yes
	Speech Abnormality	no	yes
	Convulsion	no	yes
	Loss of Balance	no	yes
	Confusion	no	yes
	Depression	no	yes
	Crying Spells	no	yes
	Nervous Breakdown	no	yes

Signature______________________________

DATE: ______________________________

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Dr. Charles Foster Jr.** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at 478-474-3883 and requesting a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Dr Foster** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

______________________________	______________________________	________
_______Patient Printed Name	Patient Signature	Date

______________________________	______________________________	________
_______Witness Printed Name	Witness Signature	Date

FOSTER CHIROPRACTIC CLINIC

3323 NORTHSIDE DRIVE

MACON GA 31210