Account #_____

Foothills Chiropractic of Hickory, LLC 2436 N. Center St. Hickory, NC 28601 828 325-5660

Confidential Patient Information

Date_____ Name_____ Nickname if used_____
First, M.I., Last Names

Mailing Address_____ City _____ State _____ ZipCode_____
Include street type such as St., Ave., etc.

Physical Address (If different from above)_____

City _____ State _____ Zip Code_____ E-mail Address_____

Sex ____ D.O.B. _____ SS#:_____ Marital Status _____ Home Ph#(____)_____
M or F Area Code/Number

Pager (____)_____ Cell phone (____)_____ Fax (____)_____

Employer _____ Employment Info: Status: ❑ Full time ❑ Part time ❑ Retired ❑ Not employed

Work phone (____)_____ Extension _____ Work mailing address_____

City _____ State _____ Zip Code_____ Work Website_____

If Student: Status: Full time_____ Part time_____ School_____

Insurance Info: Insurance Name_____ Policy #_____ Group_____

Insurance Phone# (____)_____ Primary Insured (if different than patient)_____

Primary Insured D.O.B._____ Primary Insured 's Mailing Address (if different than patient) _____

City _____ State _____ ZipCode_____ Primary Insured's Employer_____

Employer Mailing Address_____ City _____ State _____

Zip Code_____ Name of nearest relative (not your spouse) _____ Phone _____

Who referred you to our office? _____

Is your visit due to an accident? (Auto or work) ❑ No ❑ Yes (If yes, please see receptionist for an injury report.)

Your Present Complaint (Briefly describe your symptoms and date this condition began) _____

_____

List other doctor(s) seen for this condition_____

Medical History (if any of the following are relevant to your medical history, please check accompanying box)

- ❑ Stroke
- ❑ Carotid Artery Disease
- ❑ Dizziness
- ❑ Nausea
- ❑ Loss of Consiousness
- ❑ Visual Disturbances
- ❑ Pass Out Easily
- ❑ Difficulty w/speech
- ❑ Hepatitis
- ❑ Concussion
- ❑ Convulsions
- ❑ High Blood Pressure
- ❑ Swallowing Trouble
- ❑ Balance Problems
- ❑ Numbness on one side of your face or body
- ❑ AIDS
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ HIV/ARC
- ❑ Asthma
- ❑ Heart Trouble
- ❑ Cancer
- ❑ Pacemaker
- ❑ Polio
- ❑ Digestive Disorders
- ❑ Backaches
- ❑ Numbness
- ❑ Arthritis
- ❑ Venereal Disease
- ❑ Diabetes

If female: Are you pregnant? ❑ Yes ❑ No. Date of last menstrual period? _____

Since your symptoms began, have you noticed a change in ❑ Bowel Function ❑ Bladder Function ❑ No Change

Please mark on your body where you have any pain or unusual sensations

On a scale of zero to 10, I rate my discomfort as follows:

Neck-Shoulder-Arm-Pain (_____) 0 no pain 10 severe pain

Mid Back Pain (_____) 0 no pain 10 severe pain

Low Back and Leg Pain (_____) 0 no pain 10 severe pain

Foothills Chiropractic of Hickory, LLC, 2436 N. Center St., Hickory, NC 28601 (828) 325-5850

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit 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. It is my understanding that my credit may be checked if Foothills Chiropractic of Hickory, LLC extends credit to me and 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, unless prior arrangements are made. I hereby authorize the doctors at Foothills Chiropractic of Hickory, LLC and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct. *PLEASE NOTE: There will be a $30.00 returned check fee and a $30.00 no-show fee per session.

_____ _____

Signature of Patient (Parent or Guardian if patient is under18) Date

If you have insurance, please read and sign the following:

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Foothills Chiropractic of Hickory, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, choice in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provisionwithin 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

Automobile Accident Questionnaire

Patient Name:_____ Date of Birth:_____

Insurance Information

Insurance carrier for <u>your</u> vehicle

Name of policyholder: _____
Name of Ins: _____
Address: _____
Phone #: _____
Policy #: _____
Claim #: _____
Adjuster: _____

Insurance carrier for <u>other</u> vehicle

Name of policyholder: _____
Name of Ins: _____
Address: _____
Phone #: _____
Policy #: _____
Claim #: _____
Adjuster: _____

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 accident happened: _____
Please explain in detail how your accident happened: _____
_____
_____
Name of driver in **your** vehicle: _____
Name of driver in **other** vehicle: _____
How many passengers were in your vehicle? _____ Other vehicle? _____
Were police notified? ☐ Yes ☐ No Did your head strike windshield or object? ☐ Yes ☐ No
Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
Were you struck from: ☐ Behind ☐ Front ☐ Passenger side ☐ Driver side
You were: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Wearing seat belt ☐ other protective device
When did you feel pain? ☐ Immediately after accident ☐ later that day ☐ next day ☐ _____
Where did you feel pain? _____
Where were you taken after the accident? _____
What treatment was given? _____
Did you consult any doctor after the accident? ☐ Yes ☐ No If yes, who? _____
What was diagnosis? _____
What treatment was given? _____
How many times did you see the doctor? _____
Have you ever had any complaints in the same area before? ☐ Yes ☐ No If yes, when? _____
What were the complaints? _____
Before this 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
Since this injury, are your symptoms: ☐ Improving ☐ getting worse ☐ the same

Patients Signature:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Account #_____

Foothills Chiropractic of Hickory, LLC

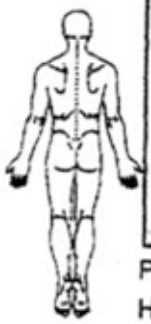
HISTORY OF PRESENT ILLNESS

PATIENT'S NAME: _____ DATE: _____

REFERRAL: _____

DOCTOR: _____ NPA: _____

MAJOR COMPLAINT: _____



HISTORY	RELEVANT TRAUMAS: ❑ Auto Accidents ❑ Slips ❑ Falls ❑ Sports
ADDITIONAL COMPLAINTS:	FAILED TREATMENT:

Previous Chiropractic treatment? ❑ Yes ❑ No What were you treated for? _____

How long were you under care? _____ Approx. day since last adjustment _____

WHEN FIRST NOTICED THIS: _____

HAS IT HAPPENED BEFORE ? _____

WORSE/BETTER (A.M./P.M.): _____

ANY RADIATION OF PAIN TO AN EXTREMITY? (WHERE): _____

DOES ANY POSITION RELIEVE YOUR PAIN? (WHICH ONE?) _____

LOCATION: _____

QUALITY: ❑ Sharp ❑ Burning ❑ Aching ❑ Shooting ❑ Stabbing ❑ Dull ❑ Tingling _____

FREQUENCY (PAIN): _____

DURATION (PAIN): _____

SEVERITY (PAIN): ❑ Mild ❑ Moderate ❑ Severe _____

WHAT HAVE YOU DONE TO TRY TO HELP YOURSELF? ❑Ice ❑Heat ❑Linament ❑Exercise _____

ANY ASSOCIATED SIGNS & SYMPTOMS? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

ANYONE RECOMMEND MEDICATION? ❑ Yes ❑ No: MEDICATION TAKEN FOR THIS CONDITION: _____

ANYONE RECOMMEND SURGERY? ❑ Yes ❑ No: _____

DIAGNOSTIC PROCEDURES PERFORMED: ❑ MRI ❑ CAT SCAN ❑ X-RAYS Other: _____

RATED 1 TO 10 (NOW/WORST): _____

HPI Continued

SPINAL CHORD PRESSURE			Onset/Frequency Duration Intensity
1)	❒ past ❒ present	HEADACHES	❒ Negative _____
2)	❒ past ❒ present	DIZZINESS	❒ Negative _____
3)	❒ past ❒ present	BLURRED VISION	❒ Negative _____
4)	❒ past ❒ present	LOSS/CONCEN.	❒ Negative _____
5)	❒ past ❒ present	DEPRESSION	❒ Negative _____
6)	❒ past ❒ present	NERVOUSNESS	❒ Negative _____
7)	❒ past ❒ present	DIFFICULTY SLEEPING	❒ Negative _____
8)	❒ past ❒ present	LOSS OF ENERGY	❒ Negative _____
9)	❒ past ❒ present	TIRED A.M.	❒ Negative _____
10)	❒ past ❒ present	BUZZ/RING/EAR	❒ Negative _____
11)	❒ past ❒ present	RUN DOWN	❒ Negative _____
12)	❒ past ❒ present	FAINTING	❒ Negative _____
13)	❒ past ❒ present	PALPITATION	❒ Negative _____

GENERAL PROBLEMS WITH FOLLOWING			
1)	❒ past ❒ present	HEAD/Ears/Nose/Throat	❒ Negative _____
2)	❒ past ❒ present	GLANDS/Throid/Diabetes	❒ Negative _____
3)	❒ past ❒ present	NECK PAIN/STIFFNESS	❒ Negative _____
4)	❒ past ❒ present	SHOULDER/ARM PAIN (R/L)	❒ Negative _____
5)	❒ past ❒ present	SKIN/Redness/Rash	❒ Negative _____
6)	❒ past ❒ present	UPPER BACK	❒ Negative _____
7)	❒ past ❒ present	MID BACK	❒ Negative _____
8)	❒ past ❒ present	CHEST PAIN	❒ Negative _____
9)	❒ past ❒ present	LUNG	❒ Negative _____
10)	❒ past ❒ present	HEART	❒ Negative _____
11)	❒ past ❒ present	STOMACH	❒ Negative _____
12)	❒ past ❒ present	DIGESTION	❒ Negative _____
13)	❒ past ❒ present	BLADDER	❒ Negative _____
14)	❒ past ❒ present	LIVER	❒ Negative _____
15)	❒ past ❒ present	KIDNEY	❒ Negative _____
16)	❒ past ❒ present	COLON	❒ Negative _____
17)	❒ past ❒ present	CONSTIPATION	❒ Negative _____
18)	❒ past ❒ present	LOW BACK	❒ Negative _____
19)	❒ past ❒ present	HIP/LEG PAIN (R/L)	❒ Negative _____
20)	❒ past ❒ present	POOR CIRCULATION	❒ Negative _____

PREVIOUS INJURIES

1) HOSPITAL/SURGERY ❒ Yes ❒ No: _____

a) IF FEMALE, BREAST REDUCTION / IMPLANTS ❒ Yes ❒ No: _____

2) ACCIDENTS (AUTO/FALLS) ❒ Yes ❒ No: _____

3) ACCIDENT ON JOB ❒ Yes ❒ No: _____

I confirm I have reviewed the information recorded here. _____ Date _____

(Dr. Signature if s/he did not take the history)

ELIZABETH BEADLE, D.C. MA, CCSP, DIPL, AC

LIEN

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to Elizabeth Beadle, D.C. at Healing for Life, PLLC such sums as may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien, and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts including, but not limited to all court costs and attorney fees. I fully understand that upon settlement, by signing this agreement and without exception, I cannot use G.S. 44.49, Supplement or G.S. 44.50. The above general statutes mention recoveries for personal injury. I acknowledge my acceptance by my signature, which is witnessed and notarized to waive use of the above general statutes. Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

_____ _____

Patient or Guardian Signature Date Witness Signature Date

IN WITNESS WHEREOF, the parties hereto have herein affixed there hands and seals in duplicate counterparts, the day and year written above.

_____ My

Commission expires _____ SEAL
Notary

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said Doctor above named.

_____ _____

Attorney Signature Dated

2436 North Center Street Hickory, NC 28601 Phone: 828-325-5850 Fax: 828-325-5852

RECISION OF ATTORNEY ASSIGNMENT OF BENEFITS

Patient _____

Insured _____

Date of Injury _____

Claim # / Policy # _____

Social Security # _____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my chiropractor.

Name: Elizabeth Beadle, D.C. at Healing for Life, PLLC

Address: 2436 N. Center Street, Hickory, NC 28601

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my chiropractor, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney should receive payments of my medical bills, except the treating chiropractor for the remainder of this claim.

Thank you for your cooperation in this matter.

_____ _____

Patient/Insured Signature **Date**

Waiver by Insured
Of Health Care Policy Terms to Permit
Treating Chiropractor to Recover From
Collateral Sources for Services Rendered

I, the undersigned, being of sound mind and eighteen years of age and older, do hereby waive any applicable terms of my current health care insurance policy or any other requirement that may restrict my treating chiropractor, Elizabeth Beadle, D.C., (herein after referred to as "Chiropractor"), from seeking to collect reimbursement for health care services rendered by her and for which reimbursement is due me from collateral sources, to the extent permitted below. Such collateral sources may include, but are not limited to: automobile medical payments insurance, automobile liability insurance, and third party recovery through court action or in settlement thereof.

I further acknowledge that Chiropractor will not be limited to receiving the contractual rate for services provided in my current health care insurance policy, but may recover from other sources based upon his usual and customary rates. Notwithstanding the above, if I request coverage for these services under my health care insurance policy, Chiropractor may collect only the difference between the amount he/she has received from my health care coverage for services rendered and the amount of collateral payment for such services.

I further acknowledge that the amounts due to Chiropractor as permitted by this waiver shall be considered an indebtedness for unpaid medical expenses subject to the creation of a lien for the purposed Article 9, Chapter 44 of the General Statutes.

This waiver has been executed simultaneously in counterparts, each of which shall be deemed an original. At least one copy shall be left with the undersigned insured and another retained by the Chiropractor named above.

I have been informed and understand that I am not required to execute this waiver, and that my execution of this waiver is in no way a precondition of receiving services from Chiropractor.

Signature _____ Date _____

Print Name _____

Health Insurance Co. _____ Policy # _____

Assignment and Instruction for Direct Payment to Doctor, Private and Group Accident and Health Insurance

Patient _____

Employer _____

Claim # / Group # _____

SS # /ID # _____

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

Healing for Life, PLLC
2436 N. Center Street
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 Healing for Life, PLLC
2436 N. Center Street
Hickory, NC 28601

I direct you to pay the professional or medical expense benefits allowable, and otherwise payable to me under current policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNEMTN 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.

Dated at _____ this _____ day of _____ 20_____

_____ _____
Signature of policy holder **Witness**

_____
Signature of claimant, if other than policy holder

DR. E BEADLE DC, MA, CCSP, DIPL. AC (NCCAOM)

NAME: _____ DATE: _____

DIFFERENTIAL DIAGNOSIS

- What complaints / conditions do you have?
- Please list the order in which you would like these conditions treated.
- What time of the day are these conditions worse?

	Condition	Time	Re-Exam (office use only)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

(Examples include: back and neck pain, headaches, shoulder, knees, wrist, TMJ, eyes, ears, nose and throat (E ENT), heart, lung, digestive, urinary, reproductive, skin, hormone, thyroid, allergies, depression, anxiety, insomnia, lack of energy)

- In oriental medicine dreams and emotions are significant in our diagnosis.

Do you have vivid dreams? ☐ YES ☐ NO

- What emotions are most prevalent? (circle all that apply)

anger	worry	joy	panic	anxiety	sadness
tears	fear	grief	weeping	obsession	

2436 North Center Street, Hickory, NC 28601 * (828) 325-5850 * (828) 325-5852

ELIZABETH BEADLE, D.C. MA, CCSP, DIPL, AC

Patient: _____ Date: _____

S.S. #: _____ D.O.B.: _____

Authorization for Use or Disclosure of Protected Health Information:

I, the above-identified patient, or my legal representative, hereby authorizes use or disclosure of protected health information about me to be furnished to Healing for Life, PLLC at their address below, all records, x-rays, MRI reports and excerpts of all records and/or prognosis, care and treatment, billing or opinions rendered concerning any and all conditions that the above-identified patient has had in the past, may have now, and may in the future. I understand that the information used or disclosed may be subject to re-disclosure by Healing for Life, PLLC and would then no longer be protected by federal privacy regulations. This information is needed by Healing for Life, PLLC and is voluntarily disclosed by me.

I authorize the use of this medical release and any reproductions thereof to satisfy any State/Federal regulations. All records faxed are received in a secure location and will be protected/secured according to the regulations of HIPPA. I may revoke this authorization by notifying Healing for Life, PLLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

This authorization expires one year from the above date.

( ) I certify that I am the above-identified patient.

( ) I certify that I am the legal guardian of the above-identified patient.

Revocation of All Prior Authorizations:

I, hereby revoke all previous authorizations given by me for the release of medical information for any reason and/or purpose whatsoever, and specifically request that NO medical information of any nature be shown, discussed, or released to any party other than Healing for Life, PLLC; with the EXCEPTION of insurance providers and other healthcare providers as deemed necessary for the continued healthcare for the above-identified patient.

( ) I certify that I am the above-identified patient.

( ) I certify that I am the legal guardian of the above-identified patient.

X_____
Signature

2436 North Center Street Hickory, NC 28601 Phone: 828-325-5850 Fax: 828-325-5852