BESHEL CHIROPRACTIC CENTER

2551 S. Church St., Burlington, NC 27215
336-586-0101 Dr. John P. Beshel

101 Ivey Rd., Graham, NC 27253
336-227-6000 Dr. Timothy J. Beshel

PATIENT INFORMATION						*Today's Date*	
Last Name			First			M.I.	
Street Address						Unit/Apt #	
City / State / Zip							
Home Phone			Email				
Cell Phone			Date of Birth				
Work Phone			Social Security #				
Gender	M F	Age:	Marital Status	Married Single Divorced Widowed			
If a minor, name of legal guardian							
How did you hear about our office?							

EMERGENCY CONTACT			
Name		Relationship	
Address			
Home Phone		Cell Phone	

MEDICAL INSURANCE INFORMATION			
Insurance Carrier		ID Card #	
Policy Holder		Policy Holder Date of Birth	
Employer of Policy Holder		Policy Holder SSN	

REASON FOR VISIT			
Reason for today's visit			
When did this begin?		Has this occurred before? YES NO	
How did this occur?			
Was this Auto Related? YES NO		Was this Job Related? YES NO	
Did you see a doctor for this? YES NO	If Yes, who?		
Type of treatment received			
Were you satisfied with the treatment? YES NO	If No, explain		

HEALTH INFORMATION			
Primary Care Physician		Phone	
List all current medication			
List all current Health Conditions			
List **ALL** Surgeries			
Prior Chiropractor Care? YES NO	If Yes, who?		Date

FEMALES ONLY (Please Circle) — I AM: PREGNANT NOT PREGNANT UNSURE

PREVIOUS INJURIES	Date of occurrence		Date of occurrence
Back Injury		Head Injury	
Broken Bones		Industrial Accident	
Disability		Joint Injury	
Fall (Severe)		Laceration (Severe)	
Fractures		Motor Vehicle Accident	
Soft Tissue Injury		Other	

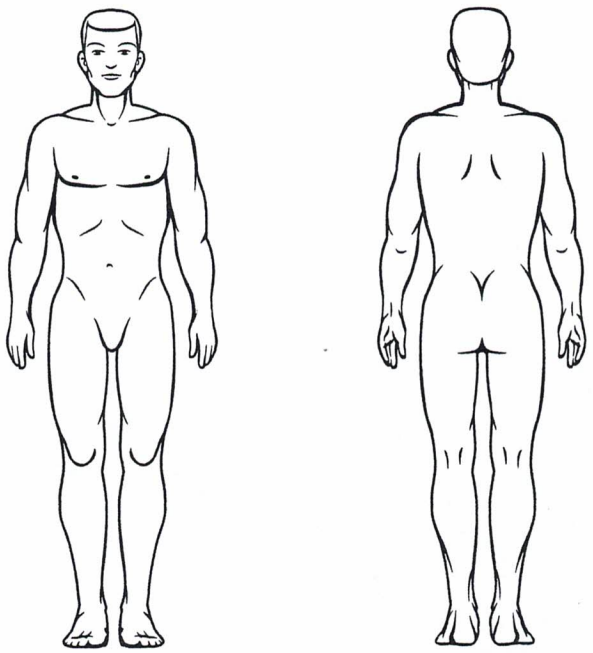
Do you smoke / chew? NO YES _____ Per Week	Do you drink? NO YES _____ Per Week

FAMILY HISTORY	Family Member		Family Member
Arthritis		Asthma / Hay Fever	
Back Trouble		Bursitis	
Cancer		Constipation	
Diabetes		Disc Problem	
Emphysema		Arm / Hand Pain	
Headaches		Heart Trouble	
High Blood Pressure		Insomnia	
Numbness		Liver Trouble	
Migraines		Neuralgia / Tingling	
Pinched Nerve		Scoliosis	
Sinus Trouble		Stomach Trouble	

IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING CONDITIONS, PLEASE INDICATE ON THE DIAGRAM BELOW.

A = ACHE **B = BURNING** **N = NUMBNESS**

P = PAIN **S = STABBING** **O = OTHER**



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Beshel Chiropractic Center 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 Beshel Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 of treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____

Patient's Signature

_____

Date

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BESHEL CHIROPRACTIC CENTER

202 South Main St., Unit – K
Graham, NC 27253
336-227-6000

Dr. John P. Beshel

Dr. Tim Beshel

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 Beshel Chiropractic Center 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 Beshel Chiropractic Center any proceeds or compensation that I am or may become entitled to receive as a result of my injuries 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 Beshel Chiropractic Center, 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 as are due or may become due to Beshel Chiropractic Center for its services rendered.

I appoint Beshel Chiropractic Center as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Beshel Chiropractic Center.

I authorize Beshel Chiropractic Center to release 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 facilitate collection of proceeds under this assignment.

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

_____ _____

Legal Guardian Print | Printed Name

_____ _____

Legal Guardian Signature | Patient Signature

_____ _____

Date | Date

NOTICE OF LIEN

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

Beshel Chiropractic Center 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. Beshel Chiropractic Center agrees to be bound by any confidentiality agreements the contents of the accounting.

BESHEL CHIROPRACTIC CENTER

By: _____

BESHEL CHIROPRACTIC CENTER

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2551 South Church Street
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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 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.

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 the notice before you sign this consent form (165.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our policy 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

Your may revoke your consent to us at any time; however your revocation must be in writing. 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. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to our health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Signature
_____	_____
Signature	Date
_____	
Date	

"Good health through chiropractic care"

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Appointment Reminders 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 and information.

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 our health information if they decide to contest any of our claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information any may no longer be protected by the federal privacy rules.

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 (164.524).

This notice is effective as of _____. 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**

_____ _____
Patient Signature **Authorized Provider Representative**

_____ _____
Personal Representative Printed **Personal Representative Signature**

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

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____