2253 Brodhead Rd. Aliquippa PA 15001
P. 724-203-0783 F. 724-203-4347
Skylinechiro12@gmail.com

# Patient Information Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Gender: Male Female

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail Address: _____

Occupation: _____ Employer: _____

Preferred Method of Contact: □ Home □ Cell □ Work □ Email
Preferred Method of Appointment Reminder: □ Call Home □ Call Cell □ Text □ Email
Married: □ Yes □ No □ Divorced

Spouse Name: _____ Number of Children: _____

Emergency Contact: _____ Relationship: _____ #: _____

**How Did You hear about Skyline Chiropractic & Sports Medicine?**

Referral: □ _____ Internet: □ _____

Sign: □ _____ Insurance Directory: □ _____

Newspaper: □ _____ Other: □ _____

---

Is your appointment today related to: □ Auto Accident □ Work □ Sports

Primary Complaint: _____

How long have you had this? _____

*Secondary Complaint*: _____

How long have you had this? _____

**Other Complaints**: _____

How long have you had this? _____

**Patient Name**: _____ **Date**: _____

**Please list the symptoms for which you are seeking our help:**

Have you ever had chiropractic care before: □ Yes □ No

Chiropractors name: _____ Location: _____

Were x-rays taken? □Yes □ No Date Taken _____ Last visit: _____

**Current Medical Condition (Please Mark Yes or No)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Asthma | □ | □ | Chest Pain | □ | □ |
| Shortness of Breath | □ | □ | Stroke | □ | □ |
| Hernia | □ | □ | Pregnancy (current) | □ | □ |
| Arthritis | □ | □ | Numbness or Paralysis | □ | □ |
| Allergies | □ | □ | Heart Disease | □ | □ |
| Diabetes | □ | □ | High Blood Pressure | □ | □ |
| Osteoporosis | □ | □ | Osteopenia | □ | □ |

**Current or Previous Health Conditions**

□ Fatigue, Loss of Energy □ Heartburn □ Stress
□ Sleep Problems □ Sinus Problems □ Irritability
□ Headaches: How Often? _____ □ Dizziness

Have you ever been diagnosed with cancer? □ Yes □No

Date:_____ Type: _____

Family History: □ Diabetes □ Heart Disease □ Stroke □ High Blood Pressure

---

Primary Care Providers name: _____

Last Physical Exam: _____ Reason for last visit: _____

Do I have permission to send a report to your PCP: □Yes □ No

Do you take prescription medicine? □Yes □ No

Are you currently taking steroids? i.e. prednisone, corticosteroids etc. □ Yes □ No

If yes, please list each medication and the condition for which it is prescribed:

_____

_____

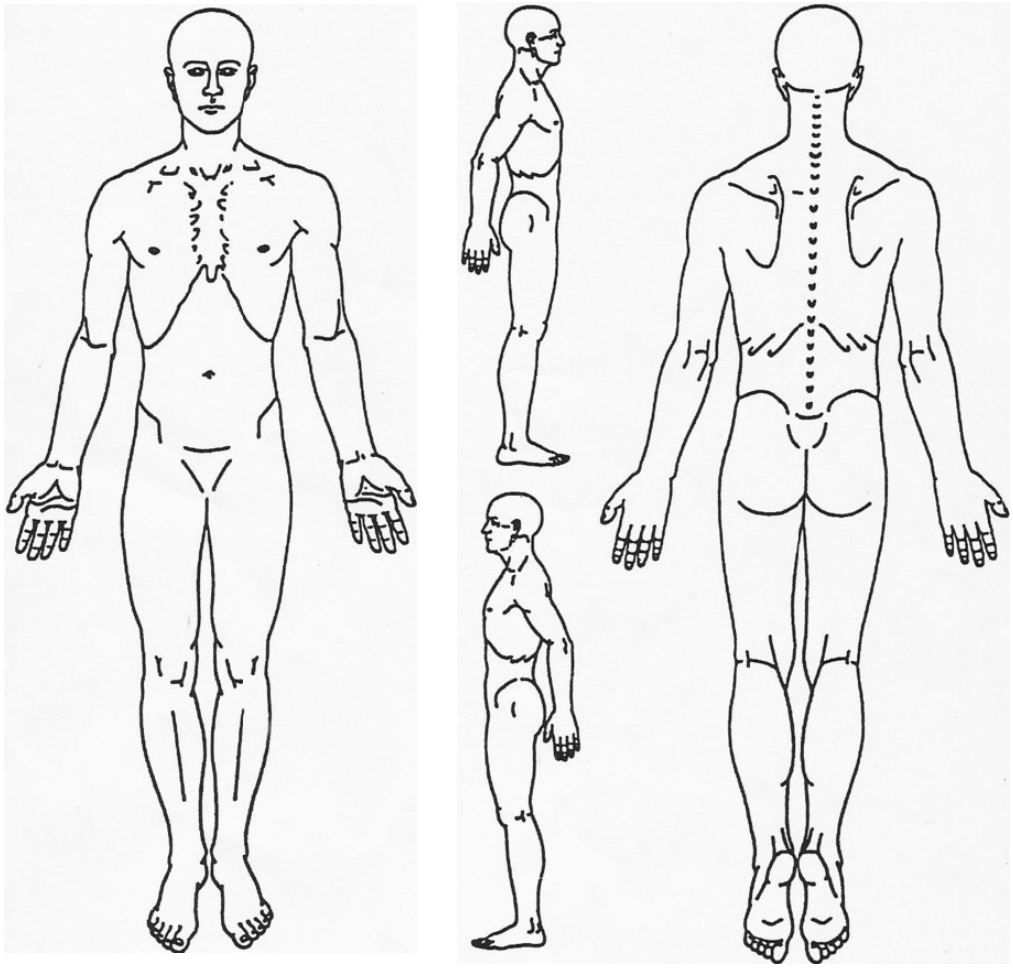
_____

_____

# PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a j, Lorarrow to indicate the direction of radiating pain.
(Include all affected areas)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **A=** | **Ache** | **B =** | **Burning** | **R =** | **Radiating Pain** | **D =** | **Dull Pain** |
| **N=** | **Numbness** | S = | **Stabbing** | **P =** | **Pins & Needles** | **O =** | **Other** |



**Please indicate how you would rate your pain** (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)_____

How long have you experienced neck/back pain? Years Months Weeks
Is this your first episode of neck/back pain? YES NO

SIGNATURE:_____

DATE:_____

## Insurance Information

Insurance Company: _____ Member ID #: _____

Name of Policy Holder: □ Self or □ Other: _____

Policy Holders Date of Birth: _____

**My Authorization**

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

Patient Signature_____ Date _____
(Signature of patient or person acting on patient's behalf)

# Skyline Chiropractic Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. I have instructed my staff to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to avoid any disagreement over payment for professional services.
- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients are requested to establish financial arrangements for payment of their account by insurance by insurance or personally.

- Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance and insure your carrier remits payment, this includes deductibles and co-payments. If a problem occurs with your insurance, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.

- Every 14 days you will receive a statement for services which is due and payable within 10 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

- All patients who have not paid for treatment within 61 days of being billed without pending insurance or financial arrangements, may be refused further credit until the previous balance is paid in full or written financial arrangements are accomplished. Please notify us immediately if a mistake appears on the statement.

If you have any questions concerning my policy or need assistance, please contact us immediately.

I understand that all health services rendered to me and charged to me are my personal financial reasonability. I understand and agree to the conditions of this policy.

_____ _____
Signature Date

**Missed Appointments**
It is the policy of Skyline Chiropractic and Sports Medicine to assess a missed visit fee to patients who cancel appointments with less than a 24-hours' notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits greatly affect us. The time lost could have been used to provide care for others. _____ My initials here indicate that I understand the above missed visit policy.

2253 Brodhead Rd. Aliquippa PA 15001
P. 724-203-0783 F. 724-203-4347
Skylinechiro12@gmail.com

# Acknowledgement of Receipt of Notice of Privacy Practices

***This form will be retained in your medical record.***

## NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:**_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Skyline Chiropractic and Sports Medicine

I understand that the Notice describes the uses and disclosures of my protected health information by Skyline Chiropractic and Sports Medicine and informs me of my rights with respect to my protected health information.

*Patient's Signature or that of Legal Representative*

*Printed Name of Patient or that of Legal Representative*

*Today's Date*

*If Legal Representative, Indicate Relationship*

## FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

*Employee Name*

*Today's Date*

**CONSENT for COMMUNICATION via E-MAIL**

Skyline Chiropractic and Sports Medicine

I, _____, hereby consent to have my physician Daniel G. Zorn, D.C., communicate with me or members of his staff, where appropriate via e-mailing regarding the following aspects of my medical care and treatment: [appointments, billing, newsletter, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, regarding my medical care and treatment will be printed out and made a part of my medical record. **I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e- mail.**

*We are happy to respond to your inquiry, but in order for us to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your query.*

*If you wish to conduct this discussion via email, please indicate your acceptance of this risk with your email reply. You may withdraw your consent at any time. Alternatively, please contact our office to arrange a telephone conversation or office visit if you decide against corresponding via email.*

*Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.*

□ *I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____.*

□ *I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is _____.*

□ *I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.*

Signature _____ Date _____