

JOHNSTON CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION

Driver's License #: _____ Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

E-mail Address: _____

Age: _____ Birth Date: _____ Marital Status: Married Single Widow Divorced # of Children: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Nearest Relative: _____

Referred By: _____

Date of last physical examination: _____

What operations have you had? _____ When? _____

Serious Illnesses? _____ When? _____

Have You Suffered From:

- | | | | |
|---|--|---|---|
| Dizziness: <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis: <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Backache: <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No | Neuritis: <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches: <input type="checkbox"/> Yes <input type="checkbox"/> No | Digestive Disorders: <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness: <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness: <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Purpose of this appointment: _____

Other doctors seen for this condition: _____

Have you been treated for any health condition by a physician in the last year? Yes No

Describe: _____

What medications or drugs are you taking? _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE
 INFORMATION REQUESTED ON THE REVERSE SIDE

Remarks and additional information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: X _____

ARE YOU INSURED? YES NO COMPANY X _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Johnston Chiropractic Clinic 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 Johnston Chiropractic Clinic will be credited to my account on 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: X _____ Social Security #: X _____ Date: X _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

Information Taken By: _____ Date: _____

**IF YOURS IS AN ACCIDENTAL INJURY,
PLEASE ANSWER THE FOLLOWING QUESTIONS.**

Date of Accident: _____ Time of Accident: _____ AM PM Location: _____

How did the accident occur? Auto Collision On-the-job Injury Other: _____

Please describe the circumstances: _____

Did you report the injury to your foreman or employer? YES NO

Did they recommend care at our office? YES NO

If it was an auto collision, were you the: Driver Passenger Pedestrian

List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? YES NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Have you lost any days of work? YES NO If so, what dates: _____

Insurance Companies Involved:

My Company _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES NO

Do you have an attorney that has advised you in this case? YES NO

Name: _____ Address: _____ Phone #: _____

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**JOHNSTON
CHIROPRACTIC
CLINIC**

DR. PAUL F. JOHNSTON

AUTHORIZATION AND ASSIGNMENT

TO PAUL F. JOHNSTON, D. C.
(Name of Doctor)

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Date: X _____

Signed: X _____

Date of injury: _____

PERTINENT DATA:

Names of insurance companies believed to be involved:

My companies:

Companies of person
responsible for accident:

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

9141 WALKER ROAD • SHREVEPORT, LOUISIANA 71118 • (318) 687-9671

JOHNSTON CHIROPRACTIC CLINIC

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I understand that this authorization is valid from date of signature for seven (7) years.
2. I understand that the purpose or use of the disclosure I am granting is necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payments for that treatment and to carry out its health care operations.
3. I expressly acknowledge that this authorization is voluntary.
4. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of the authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
6. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
8. I understand that I may see and copy this information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
9. I understand that there are special privacy protections for Substance Use Disorder records and that certain Substance Use Disorder records are protected under federal law and have additional confidentiality protections. Any disclosures of Substance Use Disorder records may require specific written authorization.
10. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
11. This authorization is valid as of / / , the date I have signed below.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(Guardian, Parent if a minor)

Relationship

Witness

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**JOHNSTON
CHIROPRACTIC
CLINIC**

DR. PAUL F. JOHNSTON

ACKNOWLEDGMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services from Paul Johnston, D.C., at his Chiropractic office, and that I have been advised that the Doctor(s) providing the services is (are) willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either

- (a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or
- (b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the Doctor(s), or if I have not engaged the services of an attorney;

then payment for services rendered by the above named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

Dated the X day of _____, 20_____.

X
Patient's Signature

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.



Johnston Chiropractic Clinic
 9141 Walker Rd.
 Shreveport, LA 71118

Consent for Chiropractic Treatment and Acknowledgement of Receipt of Information

To the patient: Every type of health care is associated with some risk of a potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

- 1) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
- 2) Disc herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain, and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.
- 3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.
- 4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

-----Consent-----

I hereby authorize and direct _____, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

X Patient's name _____ Date _____ Time _____
 X Signature of patient, parent or guardian _____
 Relationship to patient _____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.
 Signature of chiropractic physician _____ Date _____ Time _____

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**JOHNSTON
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DR. PAUL H. JOHNSTON

To the Patient:

The X-rays taken at this office are part of your records. If you need them to be reviewed by another doctor, please have your doctor request these X-rays and will make a copy. A \$10.00 fee is required.

Date: _____

X

Patient Signature: _____

X

Witness: _____

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