HORNE
CHIROPRACTIC CENTER

Patient Profile

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Emergency Contact: _____ Emergency Contact # _____

How did you hear about us? _____

Health Insurance Information

Primary Insurance Co: _____

Policy Number_____ Group Number: _____

Who is responsible for this account? _____

Relationship to Patient: _____

Secondary Insurance Co._____

Policy Number_____ Group Number_____

Who is responsible for this account? _____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly Dr. David Horne/Travis Horne all insurance benefits or the benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____Date:_____

Signature of Patient, Parent, Guardian

Dr. David R. Horne **Dr. Travis D. Horne**

1105 Scalp Avenue Johnstown, Pennsylvania 15904
phone: 814-266-6121 fax: 814-262-0077
hornechiropractic.com

_____
Doctor Initial

Chief Complaint Form

Patient: _____

Describe the reason for your visit: _____

Is the condition due to an accident? ☐Yes ☐No Date of accident_____

Type of accident: ☐Work ☐Auto ☐Home ☐Other

When did your symptoms begin? ☐Today ☐ This week ☐ Within last 3 months

☐ 3 to 6 months ☐ 6 months to one year ☐ More than one year

Which word describes the frequency of your discomfort? (Select one)

☐Constant ☐Comes and goes ☐Occasional ☐Rare

Which phrases best describes changes in your discomfort during the day? (select one or more)

☐Worse in the morning ☐Worse in the afternoon ☐Worse at night
☐Changes in the weather ☐It does not change

What helps relieve your discomfort? (Select one or more)

☐Ice ☐Heat ☐Medication ☐Other (please describe) _____

Who have you seen for your symptoms? ☐No one ☐Chiropractor ☐Other
☐Medical Doctor ☐Physical Therapist

Are you still receiving treatment from another provider? ☐Yes ☐No

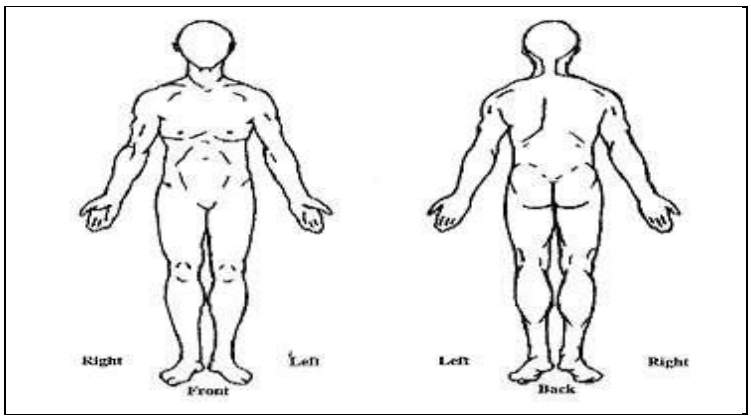
List any surgeries:_____

Do you have any spinal fusions? ☐Yes ☐No

Do you have a history of stroke/ heart attack? ☐Yes ☐No

Do you have a pacemaker? ☐Yes ☐No

Mark an "X" where you feel the pain.



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Informed Consent

Chiropractic, soft tissue techniques, and physiotherapy are very safe and effective forms of health care. It is in your best interest to be educated so that you can make an informed decision about your health. If at any time, throughout treatment, a question arises, please do not hesitate to ask the Doctor or staff. Patient education is our number one priority and we feel that an educated patient will receive greater benefit if they become involved in their own well-being.

Although it is uncommon, during any treatment there is an inherent risk of joint sprain, muscle strain, or bruising. Some patients may experience an increase in pain following the first few treatments due to muscle stretching and increased joint movement. These side effects may be temporary and the body may adapt to future treatments. All patients are thoroughly examined and will be verbally informed on the above such risks depending on what treatment is administered. I am also aware that I can discontinue my treatment at any time.

As part of your care, certain dietary supplements may be recommended to support your good health. This clinic is committed to recommending only well-documented, physician grade and science-based dietary supplements. I understand that the recommendation of certain dietary supplements may be made to support the structure and function of my body and not to diagnose, prevent, treat or cure any disease. Many of our dietary supplements have not been evaluated by the Food and Drug Administration.

_____ _____

Patient Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that you records are not readily available to those who do not need them.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient **Date**

Signature

Dr. David R. Horne Dr. Travis D. Horne

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