Office of Dr. Jason B. Jones
706 W. Ehringhaus St. Elizabeth City, NC 27909
252-335-2225

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Age: _____ Date of Birth: _____
Sex: ( ) Male ( ) Female
( ) Single ( ) Married ( ) Divorced ( ) Separated
( ) Widowed
Social Security #: _____- _____- _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Children (# and ages): _____

Type of work: _____
Insurance: Medicare ( ) Private: _____
_____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
( ) Internet ( ) Lecture ( ) Drive by ( )Website
( ) Other: _____

In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Best way to Contact You (Circle One):
Text Cell# Home# Email

Your Health Profile: Please answer all questions thoroughly

Have you had previous Chiropractic care? ___Yes ___No

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

Who is your Primary Care Physician (Regular MD)? _____
Can we send a report about your care to them? ( ) Yes ( ) No

How many Medical Doctor's office visits did you have in the last year?
( ) None ( ) Less that 5 ( ) More than 5 ( ) More than 10

Medical History

List any medications you are taking: _____

_____N/A or None.

Do you have any medically diagnosed conditions?_____

_____ N/A or None.

Does anyone in your family have any medically-diagnosed conditions (If so, whom)?:_____

_____ N/A or None.

List any previous surgeries (please give type and date): _____

_____

Doctor:_____

Lifestyle/Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Any Allergies: _____

Do you smoke? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you drink coffee? Y N If yes, how much? _____

Do you drink tea? Y N If yes, how much? _____

Daily water intake in glasses: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of vegetables in cups: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of fruits in cups: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Do you follow a particular diet (paleo, ketogenic, low fat, diabetic)? YES NO Please List_____

How regularly do you exercise? ( ) never ( ) occasionally ( ) ___x/week ( ) daily

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____ Quality of sleep (1-10)? _____

What position do you regularly sleep in? Back Side Stomach

How many hours per day do you sit on average? _____ Stand? _____

Do you work around/inhale chemicals? Yes No Explain: _____

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational	1	2	3	4	5	6	7	8	9	10
Personal	1	2	3	4	5	6	7	8	9	10

Are you currently going through a high STRESS situation? Yes No If Yes, for how long? _____

Women Only

When was your last period? _____ Are you pregnant or Nursing? ( ) Yes ( ) No ( ) Not sure

Menopause? ( ) Yes ( ) No ( ) Not sure

Past/Stress History

Please indicate whether you have **ever USED, HAD OR EXPERIENCED** any of the following. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional) _____		

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident(s) How many? _____	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional)	Y	N

Have you ever served in the US Military? Yes No >>> If Yes, What branch(es) and what years did you serve?

_____

Doctor:_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION (required by NC Law)

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 that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy 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.

Appointment Reminders

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.

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 of 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

You 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 your health information if they decide to contest any of your claims.

Patient Acknowledgement Contact ----- Circle All That Apply to You

*Cell Phone *Home Phone *Text Message *Email *All of the Above

I have read your informed consent, insurance and financial statements and privacy pledge and agree to its terms.

_____ _____

Signature of Guardian/Patient Date

INFORMED CONSENT FOR CHIROPRACTIC CARE (required by NC Law)

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. This doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

I understand that the doctor will perform an examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Be advised that at Jones Family Chiropractic, PC no cures are ever implied or promised.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

I also state that I am here for evaluation, examination, recommendations and treatment only and am here for no other purposes.

_____ _____

Signature of Guardian/Patient Date

Doctor:_____

JONES FAMILY CHIROPRACTIC, PC FINANCIAL & INSURANCE NOTIFICATIONS

Please read all thoroughly before signing - PLEASE DO NOT SKIM THIS PAGE

1) Your insurance is an agreement between you and your insurance company.
2) Jones Family Chiropractic, PC is **NOT A PARTICIPATING PROVIDER** (i.e. out of network) with any BCBS, Aetna, Cigna, Coventry, Federal BCBS, Medcost, Optima Health, United Health Care and any other insurance not listed other than Medicare.
3) We **DO NOT** verify benefits – this can be easily done by calling your insurance company. Questions to ask:
    a. What is my in-network and out of network deductible?
    b. What is my in-network and out of network copay or co-insurance?
    c. How many Chiropractic visits per year?
        i. Do these visits require pre-authorization?
        ii. Do my visits start after my deductible is met?
    d. What services are covered for Chiropractic? Please provide the codes and a description of the service
4) **Except for Medicare, you are responsible for your own insurance re-imbursement.** If you choose to self-file, we are happy to print a Superbill once a month or at the end of your corrective care plan.
5) Medicare only covers Chiropractic Adjustments in acute care. They **DO NOT COVER**: exams, x-rays, therapies of any kind, and wellness care (maintenance care).
    a. We **DO NOT FILE** Medicare secondary or supplement insurances.
6) We **DO NOT DO ANY PRE-AUTHORIZATION** for any insurance company.
7) This office **DOES NOT GUARANTEE** any insurance company will or should make partial or full payment of fees charged. We **DO NOT PROMISE** reimbursements
8) This office ***WILL NOT*** enter into a dispute with an insurance company for any reason.
9) **Tricare DOES NOT** have any Chiropractic benefits in a private practice.
10) We **DO NOT** carry balances in this office.
11) Payment is **due in full** when services are rendered. Pre-payments and payment plans may be accepted on a case-by-case basis. Payments can be made by cash, check, debit card, credit card, health savings, flex spending accounts and/or Care Credit.
12) Reports of any kind carry a $25 charge. Copies of records also carry an additional charge. X-ray written reports are $125 per set of films.
13) Marketing Authorization: From time to time our practice utilizes different marketing tools. These include, but are not limited to the internet, pictures social media, videos, flyers, newspaper ads, audio programs and direct mail. We are asking for your permission to use the wonderful testimonial/success story/photograph/video/etc. you gave us. Signing below is permission to use such materials with your consent.

WHY WE CHOOSE TO OPERATE "OUT OF NETWORK" AND HOW IT BENEFITS YOU:

1. There is no "red tape", limitations or pre-authorizations which ultimately delays your care and healing.
2. You can still file with your insurance company. When & if they provide any reimbursement, they will *pay you directly*.
3. It allows you to receive the care you need at extremely reasonable rates. Many, if not most, in-network benefits now are higher than our fees.

GOOD FAITH ESTIMATE: GOVERNMENT REQUIREMENT

We are required by the "No Surprised Act" to give a good faith estimate to ensure that no patient would receive a surprise medical bill. (Again, we do not bill patients) The average patient will be seen between 6 and 106 appointments costing between $350-7500.

COMPLIMENTARY/REDUCED RATE ACKNOWLEDGEMENT

This office periodically provides reduced-rate services. I certify, and am fully aware, that today's services rendered to me are complimentary or at a reduced rate. (Normally: $200-330) for only $_____. (not applicable to Medicare or Personal Injury)

****There is no video or audio recording of any kind allowed in this office.**

By signing below, I acknowledge, understand and accept all of the above statements.

Print_____ Signature_____ DATE _____

Doctor:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Jones Family Chiropractic, PC office Notice of Privacy Practices.

_____ _____ _____
Print Name Signature Date

Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ Emergency situation prevented us from obtaining acknowledgement
__ Other (please specify)

COVID-19 Liability Release Waiver

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which *Jones Family Chiropractic, PC*. (the "Organization") adheres to comply.

In consideration of my participation in the foregoing, the undersigned acknowledge and agree to the following:
I am aware of the existence of the risk on my physical appearance to the venue and my participation to the activity of the Organization that may cause injury or illness such as, but not limited to Influenza, MRSA, or COVID-19 that may lead to paralysis or death.
I have not experienced symptoms that of fever, fatigue, difficulty in breathing, or dry cough or exhibiting any other symptoms relating to COVID-19 or any communicable disease within the last 14 days.

I have not, nor any member(s) of my household, traveled by sea or by air, internationally within the past 30 days.
I did not, nor any member of my household, visit any area within the United States that was reported to be highly affected by COVID-19, in the last 30 days.

I have not been, nor any member(s) of my household, diagnosed to be infected of COVID-19 virus within the last 30 days.

Following the pronouncements above I hereby declare the following:
I am fully and personally responsible for my own safety and actions while and during may participation and I recognize that I may be in any case be at risk of contracting COVID-19.

With full knowledge of the risks involved, I hereby release, waive, discharge the Organization, its board, officers, independent contractors, affiliates, employees, Jones Family Chiropractic, PC representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.

I agree to indemnify, defend, and hold harmless the Organization from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVID-19.

By signing below I acknowledge that I have read the foregoing Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; That I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed; that I give my voluntary consent in signing this Liability Release Waiver as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

This waiver will remain effective until laws and mandates relevant to COVID-19 are lifted.

Signature Phone

_____ _____

Doctor:_____