Dr. J. Stephen Eggleston, DC, MS

Patient's Name_____ Birthdate_____
Last First Middle

Social Security # _____What You Prefer to be Called_____

Mailing Address_____City_____State/zip_____

Cellphone_____ Work Phone _____ Other Phone#_____

Gender: _____E-mail address:_____*

Employer_____ For How Long? _____ Full-time❑ Part-time ❑

Minor❑ Single❑ Married❑ Divorced❑ Separated❑ Widowed❑

EMERGENCY CONTACT

Name: _____Relationship: _____ Phone: _____

♥ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

♥ Our policy requires payment in full for all services rendered, at the time of the visit. Should you have a balance due on your account for some reason (ex: sometimes insurance companies give the wrong benefit and you may owe a balance) accounts over 60 days are subject to a finance charge of 1.5% monthly (18% annually). If your account becomes delinquent, you agree to pay all costs of collection, including, but not limited to, warrants in debt, attorney's fees, and fees related to credit agencies. Should there be a credit on your account we will send you a credit statement giving you the option of a refund or keeping the amount on your account.

♥ I authorize the staff and provider to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

♥ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company. Dr. Eggleston's office will, to the best of their ability, try to determine coverage. However, benefits quoted are not guaranteed as insurance companies often give the wrong benefit – the final benefit is determined by the explanation of benefits from the insurance company when they process the claim.

♥ For Medicare patients: I understand that Medicare only covers spinal manipulations that are "medically necessary" Medicare does not pay for wellness/maintenance visits. Medicare does not cover any other services.

♥ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided here.

*by providing your email address you agree to be signed up for our email notifications/newsletter. You can unsubscribe at any time by clicking the unsubscribe button at the bottom of any email.

Signature_____ **Date** _____

❑Adult patient ❑Parent or Guardian ❑Spouse

Your Name _____

BASIC HEALTH INFORMATION AND HISTORY

♥Who is your current primary care physician? _____

♥Other doctors you see (specialists, alternative care docs) ❑ None

_____

♥List all surgeries with approximate dates: ❑ None

_____

_____

♥List the medications you take: (use back of this page if more room is needed) ❑ None

_____

_____

_____

♥List all allergies: ❑ None_____

_____

Have you ***ever*** used tobacco products? ❑ No ❑ Yes ❑ Quit When? _____

If YES, about what year did you start? _____ ❑ Packs/cigars/chew (circle one) per day _____

I consume alcohol drinks: ❑ daily ❑ weekends ❑ occasionally ❑ never ❑recovering alcoholic

I exercise ❑ daily ❑ 2-3 times per week ❑ once per week ❑ never

Do you use ❑ margarine ❑ artificial sweeteners ❑ more than 1 soda per week

Are you pregnant? ❑ Yes (due date _____) ❑ No

Please check the box if you have (or have had in the past) any of these conditions:

❑AIDS/HIV	❑Difficulty breathing	❑Loss of balance	❑Pain in jaw joints
❑Allergies	❑Difficulty swallowing	❑Loss of bowel control	❑Prostate problems
❑Anemia	❑Digestive Problems	❑Loss of bladder control	❑Ringing in the ears
❑Arthritis	❑Dizziness	❑Loss of grip strength	❑Sleep apnea
❑Asthma	❑Epilepsy	❑Lung disease	❑Sore tongue
❑Cancer	❑Heart Disease	❑Migraine headaches	❑Stones
❑Chest Pain	❑Hepatitis	❑Multiple Sclerosis	❑Stroke
❑Constipation	❑High Blood Pressure	❑Osteoporosis	❑Tension headaches
❑Depression/Anxiety	❑Kidney disease	❑Pacemaker	❑Thyroid problems
❑Diabetes	❑Liver Disease/Damage	❑Parkinson's	❑Tumors

❑ Other _____ ❑ No current or past health conditions

Your Name _____

The Reason for your visit -your main complaint (s):

_____

_____

Approximate Date Symptoms First Began_____ Most recent flare-up_____

If this is from an injury, how did the injury occur?

_____

I have symptoms _____% of the day

Symptom timing *(check 1 or more of the following):*

❑Same All Day ❑*Worse in morning* ❑Worse at midday ❑*Worse at end of the day* ❑Worse at night

Please describe your pain or discomfort*. Check all that apply:*

❑Aching ❑Burning ❑Cramping ❑Deep ❑Dull ❑Numb
❑Radiating ❑Sharp ❑Stabbing ❑Stiffness ❑Tingling

Describe which activities ***worsen*** *your pain or discomfort. Select all that apply*:

❑Nothing

❑Any movement
❑Bending
❑Change position
❑Coughing
❑Driving
❑Exercise
❑Lifting
❑Looking down
❑Looking up
❑Lying on Back
❑Lying on Side
❑Lying on stomach
❑Open/Close Mouth
❑Reaching Up
❑Resting
❑Rising from seating
❑Sitting
❑Sleeping
❑Sneezing
❑Standing
❑Straightening leg
❑Twisting
❑Typing
❑Vacuuming
❑Walk down stairs
❑Walk up stairs
❑Walking

Describe which activities ***relieve*** *your pain or discomfort. Select all that apply*:

❑Nothing

❑Adjustments
❑Being still
❑Chewing
❑Extending head backwards
❑Flexing head forward
❑Heat
❑Ibuprofen/Tylenol/ Aspirin
❑Ice
❑Knees bent up
❑Lying down
❑Muscle relaxants
❑Open/close mouth
❑Prescription meds
❑Rest
❑Sitting
❑Sleeping
❑Standing
❑Straightening leg
❑Stretching
❑Topical pain reliever
❑Walking

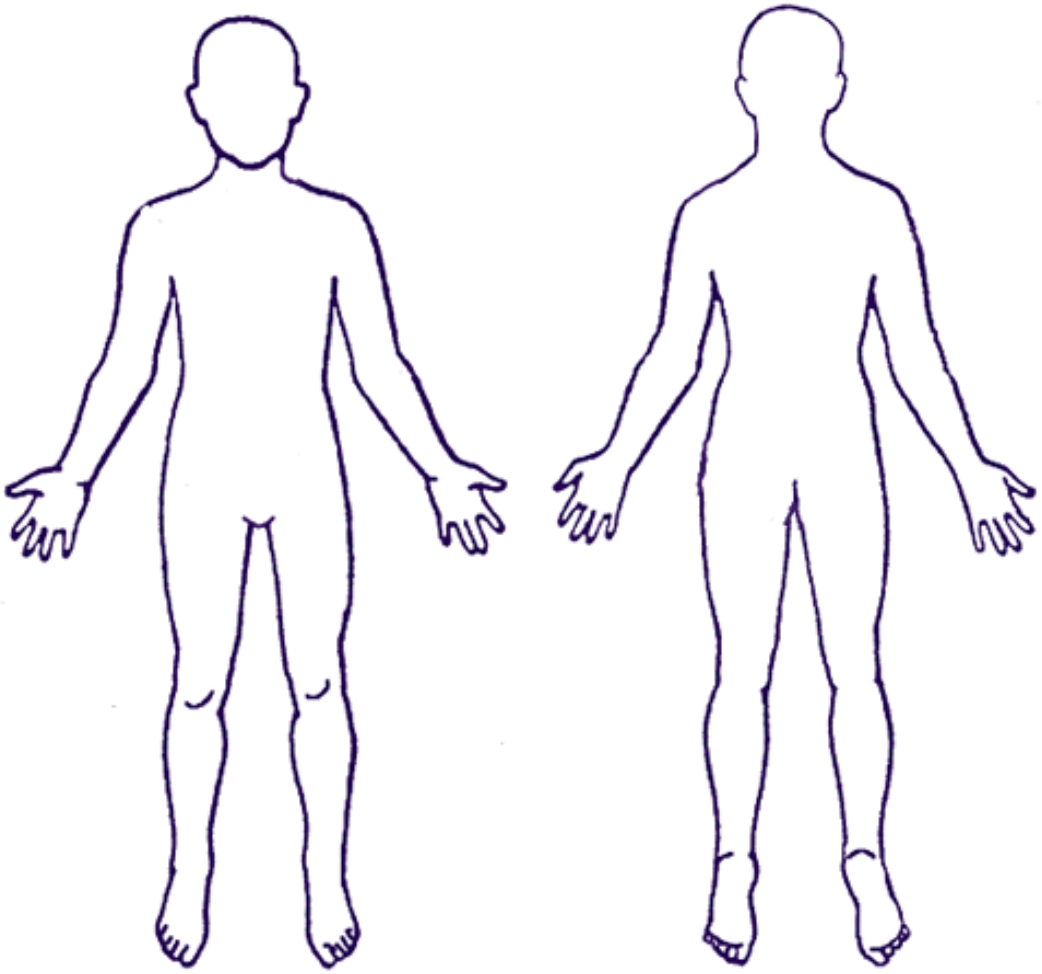
Pain Diagram and Pain Rating

Name: _____ Date: _____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles = 0000000
Burning = xxxxxx
Stabbing = //////
Deep Ache = zzzzzzz



Please rate your ***current*** level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your ***worst*** level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your ***best*** level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Your Name _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your structural problems have affected your ability to manage everyday activities. For each item below***, please circle the number with most closely describes your condition now.***

1. **Pain Intensity**

   0 (no pain) 1 (Mild Pain) 2 (Moderate Pain) 3 (Severe Pain) 4 (Worst Possible Pain)

2. **Sleeping**

   0 (Perfect sleep) 1 (Mildly Disturbed) 2 (Moderately Disturbed) 3 (Severely Disturbed) 4 (Totally Disturbed)

3. **Personal Care** (washing, dressing, etc.)

   0 (No pain) 1 (Mild Pain/unrestricted) 2 (Moderately Pain/slow going) 3 (Moderate Pain/need help) 4 (Severe/100% help)

4. **Travelling** (driving, etc.)

   0 (No pain/long trips) 1 (Mild pain/long trips) 2 (Moderate Pain/long trips) 3 (Moderate Pain/short trip) 4 (Severe Pain/short trip)

5. **Work**

   0 (Unlimited) 1 (Usual work no extra) 2 (50% of usual work) 3 (25% of usual work) 4 (Cannot work)

6. **Recreation**

   0 (Can do all activities) 1 (Most activities) 2 (Some activities) 3 (A few activities) 4 (No activities)

7. **Frequency of Pain**

   0 (No pain) 1 (Occasional/ 25% of day) 2 (Intermittent/50% of day) 3 (Frequent/75% of day) 4 (Constant/100% of day)

8. **Lifting**

   0 (No pain/heavy wt.) 1 (Increased w/ heavy wt.) 2 (Increased w/moderate wt.) 3 (Increased w/light wt.) 4 (Increased any wt.)_

9. **Walking**

   0 (No pain any distance) 1 (Increased after 1 mile) 2 (Increased after ½ mile) 3 (Increased after ¼ mile) 4 (Increased with all walking)

10. **Standing**

    0 (No pain) 1 (Increased after several hours) 2 (Increased after 1 hour) 3 (Increased ½ hour) 4 (Increased with any standing)

_____ _____

Patient Signature **Date**

Office use only

Informed Consent for care with Dr. J. Stephen Eggleston

Chiropractic care has the best safety record of any primary healthcare profession, and is even safer than dentistry, which itself has very few potential safety concerns. We want you to be informed about potential problems associated with chiropractic care before you consent to treatment. This is called "informed consent."

Chiropractic adjustments, also called manipulation, consist of the moving of certain joints of the spine and other joints with either the doctor's hands or with the use of special instruments. Frequently these cause a "pop" or "click" sound in the joint being treated. This sound is a result of nitrogen bubbles exploding inside the joint space, and is completely harmless. Some patients' joints do not make these sounds – it doesn't make any difference either way, the adjustment result is the same.

Rib fractures occur very rarely as a result of chiropractic care, but they are possible, especially in patients with severe osteoporosis. The types of procedures done in this office make these kinds of injuries nearly impossible.

Soreness may result from chiropractic treatment, just as it might from physical therapy or normal exercise. This is a temporary symptom that may occur while your body undergoes changes from the treatment. It is not dangerous, but **do please tell the doctor about it**. It is important that you not interrupt your treatment schedule because of soreness, just as you shouldn't stop going to the gym after an initial work out that makes you sore.

Super-pulsed Laser is used with some patients, and the only precaution here is that you must not look directly into the laser diodes since this might harm the eyes. We also generally do not use the laser directly over the pregnant abdomen, although there is no evidence that the laser can cause harm in this area. The laser can be safely used over pacemakers and metal implants. We also do not use the laser at the site of a suspected or proven malignant tumor.

Nutritional Supplements used in this office include whole-food concentrates, glandular products, herbs, amino acids, neurotransmitters, homeopathic medicines and antioxidants. All products come from companies with extremely high quality standards and long track records of safety and effectiveness (one of our main companies has been in continuous operation since 1929). We have dispensed most of the products for over 15 years, and have seen that side effects are basically non-existent if taken as prescribed. But, just as with medicines, we recommend that you keep all such products away from small children, especially products that contain iron.

No doctor, no system, can "fix" everything. Chiropractic is a primary care, portal-of-entry complete health care system, but we promise to recommend referrals to other types of practitioners when it seems appropriate. Often the best results are from co-care among different types of practitioners.

We do not guarantee results, but we guarantee that we will keep your best interests as the focus of our care, and will do our best to restore health to you and your loved ones. Please ask questions and voice any concerns you might have. If you don't understand something about what we are doing, please talk to the doctor. We want you to feel comfortable with the goals we set for your care, and with the tools we will use to carry out your program of care.

When you have a full understanding of this document, please sign & date below. **If care is being sought for a minor child, then this consent form will serve as "consent to treat a minor"** for one year from the date of signing unless you revoke your consent.

_____ _____

PATIENT'S NAME, ***PRINTED*** TODAY'S DATE

_____ _____

PATIENT'S ***SIGNATURE*** PARENT OR GUARDIAN ***SIGNATURE*** FOR MINOR

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your care to The Healing Center and Dr. Eggleston. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective May 15, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25.00 fee.

- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee.

- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from the practice.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

- As a courtesy, when time allows, we make reminder calls for appointments. Even if you do not receive a reminder call or message, the above Policy is still in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee for emergencies where you were not able to call (ie: medical emergencies, accidents)

You may contact us at 434.836.3506. Should it be after regular business hours, you may leave a message. Messages left via voice mail are acceptable ways to cancel.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Print Name_____

Signature (Parent/Legal Guardian) _____ Date: _____

Relationship to Patient _____

Acknowledgement of Notice of Privacy Practices

❑ NONE

If you check the "None" box you understand that we cannot share ANY information about your care, including appointment times, with *anyone*. (with the exception of insurance companies or other health professionals as outlined in the privacy policy.)

****If you would like to designate a person, or persons, with whom we may share basic information concerning your care, treatment plan or appointments, please list them here.**

_____ _____

designated person patient initials

_____ _____

designated person patient initials

_____ _____

designated person patient initials

_____ _____

designated person patient initials

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES***. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the notice. "

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

❑ Patient refused to sign

❑ Patient was unable to sign because _____

J. Stephen Eggleston, M.S., D.C.

100 Vicar Place, Danville VA 24540
(434) 836-3506

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use or disclose your health information in connection with quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose healthcare information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

PATIENT COPY

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints: If you want more information about our privacy practices, or if you have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with them upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Andrea O. Eggleston, telephone (434) 836-3506 FAX (434) 836-2407

Address: 100 Vicar Place, Danville, VA 24540-1240

Email: jsegglestondc@gmail.com

PATIENT COPY