

**Roper Chiropractic Clinic, P.A.**  
**137 N. Main Street, Fuquay-Varina, NC 27526**

<b>PATIENT INFORMATION</b>					
<b>Patient Information</b>					
ID#	<i>for office use only</i>			Home phone	
First Name:		MI		Cell phone:	
Last Name:				Nickname:	
Address:					
City:		State:		Zip:	
Date of Birth:		Age:			
Male/Female:					
Marital status:					
Social Security#:					
Email Address:					
Referred by:				Relationship to you:	
How did you hear about our office ?					
Primary Insurance Co.:				Policy No.	
Secondary Insurance Co.:				Policy No.	
Employer Name:				Your Position:	
Employer Address & phone:					
<b>“Insured’s” Information</b>					
<b>Insured’s</b> Name:	<i>if other than patient</i>		Address: <i>if other than patient</i>		
<b>Insured’s</b> DOB:	<i>if other than patient</i>		Phone:	<i>if other than patient</i>	SS#: <i>if other than patient</i>
<b>Insured’s</b> Employer Name, address, phone:					
List medications you are currently taking:					
Reason for today's visit:	Auto Accident	Workmen's Comp	Other:		
Are you seeing another doctor for this condition ?					
Does any of the following apply to you?	Heart problem	Pacemaker	Being treated for cancer ?	Epilepsy	
Spouse Name and Phone No.:					
Emergency Contact and Phone No.:					
<b>AUTHORIZATION TO TREAT</b>					
I, the undersigned patient, hereby authorize the doctor or appointed staff to administer such diagnostic testing, procedures, and treatment as are considered necessary on the basis of findings during the course of examination and treatment. I hereby certify that I have read and fully understand this Authorization To Treat. I also certify that no guarantee or assurance has been made to the results that may be obtained.					
Patient's Signature				Date:	
Guardian's Signature (for Minor)				Date:	

**Direct Assignment of Benefits and  
Authorization to Release Information**

Patient \_\_\_\_\_ Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

- I do NOT have insurance and understand that I am personally responsible for all charges for services rendered by Roper Chiropractic Clinic, PA.

- I have insurance with \_\_\_\_\_ insurance company and hereby instruct and direct said insurance company to pay by check made out and mailed to:

Roper Chiropractic Clinic, P.A.  
137 N. Main St.  
Fuquay-Varina, NC 27526

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Roper Chiropractic Clinic, P.A.  
137 N. Main St.  
Fuquay-Varina, NC 27526

for the professional expense and benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner any balance of said professional service charges over and above this insurance payment.

I understand that filing insurance does not guarantee payment and if payment is not made within 90 days by my insurance, the balance due is my responsibility.

I also authorize the release of information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize this doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this Assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Roper Chiropractic Clinic, P.A.**  
**137 N. Main Street**  
**Fuquay-Varina, NC 27526**

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used, or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to request restricted use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may be unable to treat if the consent is not obtained.

<b>The patient understands and agrees to the above:</b>	
<b>Patient Printed Name:</b>	
<b>Patient Signature:</b>	
<b>Date:</b>	
<b>Practice Representative Name:</b>	
<b>Practice Representative Signature:</b>	
<b>Date:</b>	

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

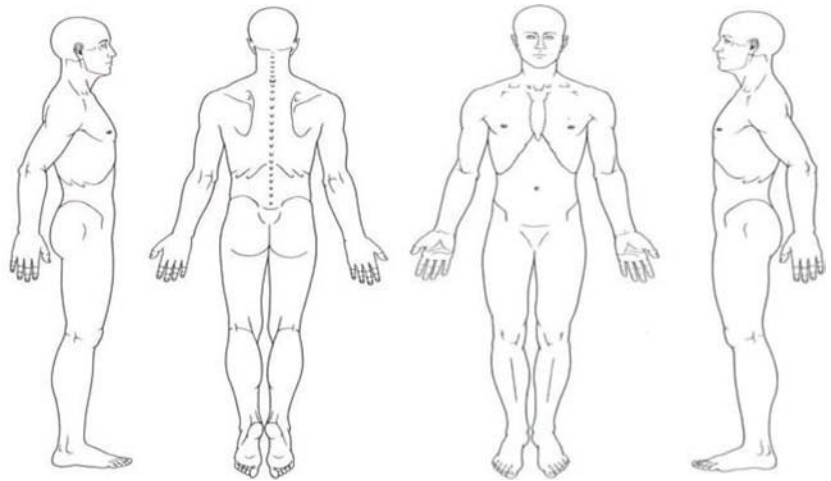
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

## 7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

## 10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



**ROPER CHIROPRACTIC CLINIC, PA**  
**JAMES P. ROPER, DC**

**Informed Consent to Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Dr. James Roper and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Roper and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

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

Patient's Printed Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Signature of patient's representative, \_\_\_\_\_  
if necessary, (e.g. if the patient is a  
minor or is physically or mentally  
incapacitated):