**WELCOME to our office!** Please allow our staff to make a photocopy of your insurance card(s) (if applicable).

**Whom may be thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Patient Information:**  **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_**  **Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_ **Sex: ** Male **** Female  **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Status: ** Single **** Married **** Divorced **** Separated **** Widowed  **If Patient is a Minor:**  **Parent/Guardian Name 1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Parent/Guardian Name 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Emergency Contact Information:**  **Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preferred Method of Contact: ** Phone Call **** Email **** Mail  **Is it ok to leave detailed messages regarding your appointments/healthcare? ** Yes **** No  **Would you like to be added to our email list for newsletters, schedule changes, updated, etc? ** Yes **** No |
| **Patient Demographic Information:**  **Preferred Language, if other than English:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Race: ** American Indian/Alaska Native **** Asian  **** Black of African Decent  **** White   Native Hawaiian/Pacific Islander  Decline to Comment  **Tobacco Use: ** Current Smoker Ex-Smoker, Quit \_\_\_\_\_\_ **** Chewing Tobacco Never Smoked |
| **Preferred Appointment Reminders:** (Please choose ONLY 1 option)  **** PhoneCall **** Email  **** Text – ***Please Indicate Phone Carrier-***  **ο** Verizon **ο** Sprint **ο** AT&T **ο** T-Mobile **ο** Cricket **ο** Nextel |
| **Employment Information:**  **Work Status: ** Full-Time **** Part-Time **** Retired **** Student  **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY COMPLAINT (Main issue bothering you today)**

1. **Describe your symptoms:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. What caused your symptoms?(lifting, bending, posture)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How are your symptoms changing: ⎕ Getting Better ⎕ Not Changing ⎕Getting Worse

1. **How often do you experience your symptoms?** ⎕Constantly ⎕Frequently ⎕Occasionally ⎕Intermittently
2. **What describes the nature of your symptoms?** ⎕Sharp ⎕Dull Ache ⎕Numb ⎕Shooting ⎕Burning ⎕Tingling
3. **Do you have numbness, tingling, or other symptoms in other areas associated with this?** ⎕Yes ⎕No
   1. If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Please rate your pain intensity ( 0 is no pain, 10 is unbearable pain)**
   1. At its best: 0 1 2 3 4 5 6 7 8 9 10 b. At its worse: 0 1 2 3 4 5 6 7 8 9 10
5. **What makes your symptoms worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your symptoms better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms are worse at what time of day?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Who have you seen for your symptoms?** ⎕No One ⎕MD ⎕PT ⎕Other Chiro ⎕Other
   1. If so, date seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Have you had similar symptoms in the past?** ⎕Yes ⎕No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HISTORY SECTION**

1. **What is your**: Height: \_\_\_\_\_\_ ft \_\_\_\_\_\_ in Weight: \_\_\_\_\_\_ lbs **Office Use Only: BP \_\_\_\_\_/\_\_\_\_\_**
2. **Any history of trauma/injury (motor vehicle accident, falls, sports injuries, etc.)** ⎕Yes ⎕No If yes, when \_\_\_\_\_\_\_\_\_\_\_\_
   1. If so, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **List any surgical procedures and times you have been hospitalized**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **History of Conditions: PLEASE INCLUDE PERSONAL AND/OR IMMEDIATE FAMILY HISTORY**

***Use Indicators: P-Personal, F-Father, M-Mother, SI-Sister, B-Brother, D-Daughter, SO-Son***

|  |  |
| --- | --- |
| \_\_\_\_\_\_ Circulatory (heart disease, heart attack,hypertension) | \_\_\_\_\_\_ Nervous (Epilepsy, Parkinson’s, MS, ALS) |
| \_\_\_\_\_\_ Respiratory (Asthma) \_\_\_\_\_\_ Urinary | \_\_\_\_\_\_ Stroke \_\_\_\_\_\_ Diabetes \_\_\_\_\_\_ Arthritis |
| \_\_\_\_\_\_ Cancer What type, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ Headaches \_\_\_\_\_\_ Depression/Anxiety |

1. **Social History:**

|  |  |
| --- | --- |
| Exercise: □ Daily □ Weekly How much? \_\_\_\_\_\_\_\_\_\_\_\_\_ | Are you under a lot of Job Pressure/Stress? □ Yes □ No |
| Alcohol Use: □ Daily □ Weekly How much? \_\_\_\_\_\_\_\_\_\_\_ | Do you use Recreational Drugs? □ Yes □ No |
| Pain Relievers: □ Daily □ Weekly How much? \_\_\_\_\_\_\_\_\_ | Are you Vaccinated? □ Yes □ No |

1. **List all prescriptions, over-the-counter medications, and nutritional supplements you are taking:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **List all known medical allergies (including latex or adhesives):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient\Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY COMPLAINT (Second issue bothering you today, if any)**

1. **Describe your symptoms:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. What caused your symptoms? (Lifting, bending, desk posture)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How are your symptoms changing: ⎕ Getting Better ⎕ Not Changing ⎕Getting Worse

1. **How often do you experience your symptoms?** ⎕Constantly ⎕Frequently ⎕Occasionally ⎕Intermittently
2. **What describes the nature of your symptoms?** ⎕Sharp ⎕Dull Ache ⎕Numb ⎕Shooting ⎕Burning ⎕Tingling
3. **Do you have numbness, tingling, or other symptoms in other areas associated with this?** ⎕Yes ⎕No
   1. If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Please rate your pain intensity ( 0 is no pain, 10 is unbearable pain)**
   1. At its best: 0 1 2 3 4 5 6 7 8 9 10 b. At its worse: 0 1 2 3 4 5 6 7 8 9 10
5. **What makes your symptoms worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your symptoms better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms are worse at what time of day?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Who have you seen for your symptoms?** ⎕No One ⎕MD ⎕PT ⎕Other Chiro ⎕Other
   1. If so, date seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Have you had similar symptoms in the past?** ⎕Yes ⎕No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIRD COMPLAINT (Third issue bothering you today, if any)**

1. **Describe your symptoms:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. What caused your symptoms?(lifting, bending, posture)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How are your symptoms changing: ⎕ Getting Better ⎕ Not Changing ⎕Getting Worse

1. **How often do you experience your symptoms?** ⎕Constantly ⎕Frequently ⎕Occasionally ⎕Intermittently
2. **What describes the nature of your symptoms?** ⎕Sharp ⎕Dull Ache ⎕Numb ⎕Shooting ⎕Burning ⎕Tingling
3. **Do you have numbness, tingling, or other symptoms in other areas associated with this?** ⎕Yes ⎕No
   1. If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Please rate your pain intensity ( 0 is no pain, 10 is unbearable pain)**
   1. At its best: 0 1 2 3 4 5 6 7 8 9 10 b. At its worse: 0 1 2 3 4 5 6 7 8 9 10
5. **What makes your symptoms worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your symptoms better?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms are worse at what time of day?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Who have you seen for your symptoms?** ⎕No One ⎕MD ⎕PT ⎕Other Chiro ⎕Other
   1. If so, date seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Have you had similar symptoms in the past?** ⎕Yes ⎕No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Use and Disclosure of Protected Health Information (PHI)**

Your Protected Health Information (PHI) will be used by Clinic FHSC PC or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices (NPP) for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. Please initial just one option.

I have received a copy of the Notice of Patient Privacy Policy \_\_\_\_\_\_\_\_\_ (Patient Initials)

I was offered a copy of the Notice of Patient Privacy Policy and declined. I understand that I may request a copy at any time. \_\_\_\_\_\_\_\_\_\_ (Patient Initials)

**Requesting a Restriction on the Use or Disclosure of Your Information**

* You may request a restriction on the use and disclosure of your Protected Health Information.
* This office may or may not agree to restrict or disclosure of your Protected Health Information.
* If we agree to your request, the restriction will be binding in this office. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal policy standards.

**Notice of Treatment in Open or Common Areas**

While our main treatment areas are in private rooms, Clinic FHSC PC does have decompression tables, therapy tables, and exercise areas that can be utilized in treatment that are in open and common areas. If you are uncomfortable with

Treatment, care, or discussion in a common or open area, you have the right and responsibility to notify the staff

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legally Authorized Individual Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Full Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Chiropractic Informed Consent**

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

**Analysis/Examination/Treatment**

As part of the analysis, examination, and treatment, you give consent to the following procedures as deemed applicable:

|  |  |  |  |
| --- | --- | --- | --- |
| • Spinal Manipulation | • Palpation | • Range of Motion Testing | • Muscle Strength Testing |
| • Orthopedic Testing | • Functional Assessment | • Basic Neurological Testing | • Postural Analysis |
| • Graston Technique | • Kinesiology Taping | • Ultrasound | • Electric Muscle Stimulation |
| • Vital Signs | • Hot/Cold Therapy | • Dry Needling | • Acupuncture |
| • Decompression |  |  |  |

**Risk Factors of Chiropractic Treatment**

As with any healthcare procedure, there are certain complications that can arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, temporarily increased soreness or pain, dizziness or nausea, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Dry Needling and Acupuncture does break the skin barrier of patients. Risks include infection, damage to organs, pneumothorax, and loss of consciousness. Every reasonable effort will be made during examination to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**Probability of Risks Occurring**

Fractures are rare occurrences and are generally a result from some other underlying weakness of the bone. The incidences of a stroke occurring are exceedingly rare; they are estimated to occur between one in one million and one in five million cervical adjustments. All other complications, noted above, are also generally described as rare.

**Availability and Nature of Other Treatment Options**

Other treatment options for your condition may include:

|  |  |  |
| --- | --- | --- |
| • Over-the-Counter NSAIDS • Rest | • Prescription Medication | • Hospitalization • Surgery |

*Be aware that if you chose one of these ‘other treatment’ options, there are both risks and benefits and you may wish to discuss these with your primary medical physician.*

**Risks and Dangers of Remaining Untreated**

Remaining untreated may allow the formation of adhesions and reduce the mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

*I have read or had read to me this Informed Consent document. I have discussed, or have been given the opportunity to discuss, any questions or concerns with the doctor of chiropractic listed below and have had these answered prior to my signing this informed consent document. Having been informed of the risks, I hereby give my consent to the performance of diagnostic testing, chiropractic manipulative treatment, and other related treatment by the doctor of chiropractic listed below and/or any other licensed doctor of chiropractic who now or in the future work at The Clinic FHSC PC.*

*I have read the Insurance and Payment Policy and understand that I am financially responsible for any and all charges whether I pay out of pocket or whether my insurance has paid their portion as per my coordination of benefits. I authorize the use of my signature on all insurance claim submissions for the purpose of obtaining insurance payment and information.*

Patient Name (Printed) Patient/Guardian Signature Date

Doctor Signature Date

**INSURANCE AND PAYMENT POLICY**

**Group or Individual Insurance**

The Clinic FHSC PC accepts most insurance plans. We accept auto accident, worker’s compensation, personal injury, and most health insurance plans including Medicare and ND Medical Assistance. Since there are so many different insurance plans and each plan varies significantly, we ask that you contact our office to assist you in getting your specific benefit coverage. Our front desk staff will gladly verify your eligibility and benefits and explain these benefits to you, at no charge. Some of the specific carriers we are providers for include, but are not limited to: **BlueCross BlueShield of North Dakota and Minnesota, Medica, UnitedHealthcare, HealthPartners, Sanford Health, Medicare, and ND Medical Assistance.** If you have an insurance carrier that is not listed please contact our office and we will help you determine if that carrier is one we can take.

**Supplemental or Secondary Insurance**

Please inform us of any supplemental or secondary insurance information you may have. Providing The Clinic with this information will enable us to submit any remaining balances carried over from primary insurance to one of these policies. Supplemental or secondary policies may not cover all of your out-of-pocket expenses, but it can help provide additional reimbursement for your medical expenses.

**Non-Insured Individuals**

It is requested that 100% of your billed charges be paid for at the time of service. We have 2 different options for patient’s paying out-of-pocket. We can provide you a 10% time of service discount or a 25% discount through a program with work with called ChiroHealthUSA (CHUSA). ChiroHealthUSA is a separate program utilized by our office that does include an annual fee of $49. Care credit is another form of credit that can be used specifically for medical expenses. The front desk will be able to assist you in any questions you may have regarding any of these options. We accept cash, check, money order, and debit/credit cards (Discover, Mastercard, or Visa) as well as flexible spending accounts and/or health savings accounts.

*\*\* Decompression, traction, acupuncture, and kinesiology taping are not subject to any discount \*\**

**Patient Payment Responsibility**

Collection of Co-Pays, Co-Insurance, and Deductibles (if applicable) are due at the time services are rendered. This policy fulfills obligations we have with insurance carriers. The Clinic staff will provide you with the most accurate estimate of patient responsibility that can be obtained prior to services being submitted for insurance payment. Benefit and eligibility information, that we receive, are not a guarantee of payment. It is understood that you, as the patient, may owe more than what was initially requested due to final determination by the insurance company. If for any particular reason you find yourself in a financial situation and are unable to pay for any these benefits up front, please contact our billing office to discuss other available payment options.

**Out-Of-Pocket Services (not billable through insurance)**

It is our policy at The Clinic that the following services will not be run through insurance and you will need to pay for these services at the time they are rendered. **The following services include: decompression, traction, acupuncture, dry needling, cupping, and kinesiology taping (aka Rocktape).** These services are not allowable to be adjusted or discounted; you will be required to pay full price for each service. You will be required to sign a financial waiver form indicating responsibility for these services; the front desk staff will go over this with you along with the cost of each service. If at anytime you wish to discontinue treatment protocol due to financial reasons, please let the front desk staff and your doctor know so we can discontinue care.

**Cancellation Policy**

A 5 hour notice, prior to your scheduled appointment, is required in the event that you need to reschedule or cancel your appointment. Missing an appointment without contacting our office, at least 5 hours prior, is considered a ‘missed’ appointment. You will be charged a $15 fee for every appointment that is missed. This fee is your responsibility and will not be sent to your insurance carrier for payment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient Initials)