TRAIN OUT PAIN CHIROPRACTIC

T.O.P

LAST NAME: _____ SEX: _____

FIRST NAME: _____ MARITAL STATUS: _____

STREET ADDRESS: _____ WHO REFERRED YOU: _____

APARTMENT #: _____ EMPLOYER: _____

CITY: _____ PERSON FINANCIALLY RESPONSIBLE (IF OTHER)

STATE: _____ NAME: _____

ZIP: _____ ADDRESS: _____

BIRTH DATE: _____ *EMERGENCY CONTACT #:* _____

HOME PHONE: _____ *NAME:* _____

WORK PHONE: _____ **INSURANCE #1:** _____

CELL PHONE: _____ **INSURED:** _____

POLICY #: _____ **GROUP#:** _____

EMAIL: _____ **RELATIONSHIP:** _____ **BIRTHDAY:** _____

INSURANCE # 2: _____ INSURED: _____

POLICY #: _____ GROUP #: _____

RELATIONSHIP TO INSURED: _____ BIRTHDAY: _____

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, **I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that a missed appointment/ late cancellation without 24 hours notice may result in a charge of $25.00.

PATIENT SIGNATURE: _____ DATE: _____

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

PATIENT SIGNATURE: _____ DATE: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. For this reason, the terms used are:

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

A.R.T.: Active Release Techniques is a process of identifying and removing soft tissue abnormalities utilizing specific contacts and ranges of motion.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Rehabilitation: personalized and specific strengthening and stabilization program, for in-office or at-home, to aid in recovery.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and soft tissue neuromuscular dysfunctions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatments for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. We do not offer advice regarding treatment by others.

Our GOAL is to eliminate dysfunction within our neuromuscular/ biomechanical systems. Our methods are specific adjusting to correct vertebral subluxation and A.R.T. I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

PATIENT SIGNATURE: _____ DATE: _____

Primary reason for visit (**ONE ONLY**- If there are other conditions ask at front desk for a separate form)

_____

When did your symptoms appear? _____
How did it start? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

What makes it worse? _____
Does the pain radiate? _____To where? _____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Shooting

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

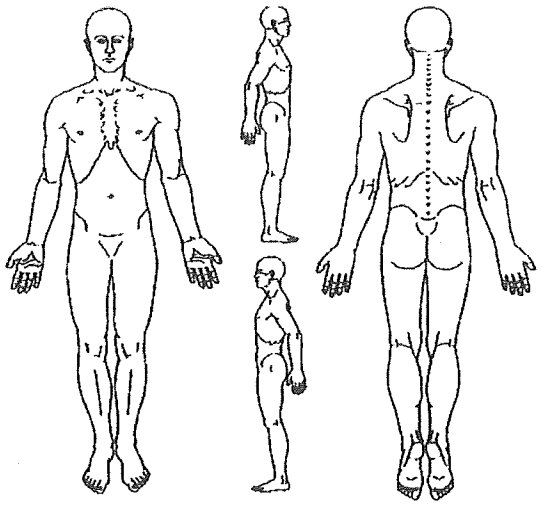
Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

What treatment have you received for this condition? ☐ Medication ☐ Surgery ☐

Physical Therapy ☐ Chiropractic ☐ None ☐ Other

Mark an "X" on the picture where you continue to have pain.



Name and address of other doctor(s) who have treated you for your condition:

_____

Name of family Physician _____
Address_____ Phone _____
What was the date of your last physical? _____ Last spinal X-ray?_____ Last MRI?_____

Are you Pregnant? ☐ Yes ☐ No Due date_____

Injuries and surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries/hospitalizations		

Is condition due to an accident? ☐ Yes ☐ No Date _____ Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of this accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other

Attorney Name_____ Phone Number _____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Reason_____

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking Packs /day_____
☐ Alcohol Drinks/week_____
☐ Coffee/ Caffeine drinks Cups/day_____
☐ High stress

Medications/ dosage	**Vitamins/ Herbs/ Minerals**	**Allergies**

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. These records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.