

## PATIENT INFORMATION

(Please Print)

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

Name \_\_\_\_\_ Date \_\_\_\_\_ Case No. \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Married/Single/Divorced/Other (Please Circle).

Referred by: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse (or parent if a minor): \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Have you had chiropractic care before? \_\_\_\_\_ When? \_\_\_\_\_ By Whom? \_\_\_\_\_

Do you have health insurance? \_\_\_\_\_ What company? \_\_\_\_\_

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## ASSIGNMENT OF PAYMENT

My attorney and/or insurance company are hereby requested and authorized to pay direct to Chiropractic Center of Monroe, S.C. any monies due on account, the same to be deducted from any settlement made on our behalf.

Further, I agree to pay Chiropractic Center of Monroe, S.C. the difference, if any, between the total amount of charges and the amount paid by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay Chiropractic Center of Monroe, S.C. the full amount of charges should my condition be such that it is not covered by my policy or if for any reason the insurance company refuses to pay my claim. I also understand a finance charge is applied to customer's accounts at the annual percentage rate of 18% or 1.5% per month. The finance charge will begin to accrue upon any invoice or portion of any invoice not paid within 60 days of that invoice.

The Chiropractic Center of Monroe, S.C. may charge a \$25.00 fee for each check presented by the undersigned customer for payment to Chiropractic Center of Monroe, S.C. which is returned unsatisfied because the drawer does not have an account with the drawee, does not have sufficient funds in his / her account or does not have sufficient credit with the drawee.

The undersigned patient hereby agrees to the finance charges and fees as set forth herein.

Dated at 765 10<sup>th</sup> Avenue, Monroe, WI 53566 this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Witness: \_\_\_\_\_ Patient/Guardian: \_\_\_\_\_

**PLEASE PRINT**

Name \_\_\_\_\_ Date \_\_\_\_\_ Case # \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your : ☐ Work ☐ Sleep ☐ Daily routine Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

List previous diagnoses and treatments you have received for present condition: \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others \_\_\_\_\_

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress \_\_\_\_\_ ☐ Comfortable ☐ Uncomfortable Do you use a bedboard? \_\_\_\_\_

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe: \_\_\_\_\_

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? \_\_\_\_\_

Have others in your family had such disorders? ☐ Yes ☐ No When? \_\_\_\_\_

**FAMILY HEALTH INFORMATION** (Many health problems are the result of hereditary spine weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:

	YES	NO
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>

	Less than 6 months	6-18 months	Over 18 months	Never
DATE OF LAST:				
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Heavy	Moderate	Light	None
HABITS				
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SEVERITY OF PAIN**  
List region of pain and circle severity number. [1 = least, 10 = greatest]

Left Right ex. Neck Right Left  
1 2 3 4 5 6 7 8 9 10

**MARK PAIN AREA**  
+++ Burning  
000 Stabbing  
--- Sharp  
III Constant

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

DO YOU:	YES	NO
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

## DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

### CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

### ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

### DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### INFORMED CONSENT FOR CHIROPRACTIC CARE

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 patient susceptible to injury. The 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. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

### RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

### TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

DATE

SIGNATURE

## CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

### 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.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. 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.

### 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 or 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 any of your authorizations 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.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

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 available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

**You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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.**

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

**You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.**

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.