Patient Information

Date: ____ / ____ / _____ Patient file number: _____
Office use only

Last name: _____ First name: _____ Middle Initial: _____

Preferred first name: _____ Gender: M____ F____

Address: _____ City: _____ State: _____ Zip code: _____
(P.O. Box NOT allowed)

Cell Carrier :_____
____ Opt out of text msg.
Home phone: _____ - _____ - _____ Cell phone: _____ - _____ - _____ ____ Opt out email msg.

Social Security Number: _____ - _____ - _____ Date of Birth: ____ / ____ / _____

Email: _____

Emergency Contact: _____ Phone: _____

Marital Status: Single Married Widowed Divorced Legally Separated
(Please circle)
Who referred you to our office? _____

Employment / Student Status:

o Employed Full Time	o Self Employed	o Retired	o Full Time Student
o Employed Part Time	o Not Currently Employed	o Active Military	o Part Time Student

Employer Information:
Name: _____

Primary Insurance:

Ins. Co. Name: _____

Policy / Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ___ Zip: ____

Date of Birth: ____ / ____ / _____

Social Security Number: ____ - ____ - _____

Relation to insured: _____

Insured Employer: _____

Primary phone: _____ - _____ - _____

Secondary Insurance:

Ins. Co. Name: _____

Policy / Group Number: _____

ID Number: _____

Insured Information (if other than self):

Name: _____

Address: _____

City: _____ State: ___ Zip: ____

Date of Birth: ____ / ____ / _____

Social Security Number: ____ - ____ - _____

Relation to insured: _____

Insured Employer: _____

Primary phone: _____ - _____ - _____

Name: _____ Date: ____/____/_____

Preferred Language: English ____ Spanish ____ Other _____

Race:

- o White
- o Black or African American
- o American Indian or Alaska Native
- o Asian
- o Native Hawaiian or Other Pacific Islander
- o Other _____

Ethnicity:

- o Hispanic or Latino
- o Non-Hispanic or Non-Latino
- o Other_____

Smoking Status:

- o Current every day smoker
- o Current some day smoker
- o Former smoker
- o Never smoked
- o

If current/former smoker, please fill in:
Started: _____

Stopped: _____

Do you have medication or food allergies?

- o No known medication or food allergies
- o Yes. What? _____

Are you currently taking any medications?

- o Not currently prescribed any medications
- o Yes
- o I have a list

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

What_____ _____ mg

Height: _____ feet _____ inches Weight: _____ pounds BP _____ / _____ R L STAFF INITIAL _____

CHIROPRACTIC HEALING CENTER

The following is an explanation of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health.

The No Charge Consultation:
We will perform a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help to improve their individual health problems. There is no charge or obligation in connection with this appointment.

Appointments:
In order to better serve our patients we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others.

Questions & Answers:
We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage. Please feel free to ask your doctor or any available staff member. Our staff will make every possible effort to answer your inquiries.

Your Privacy:
In addition to these policies, you have also been provided with a Notice of Privacy Practices comprehensively describing your information, its uses and disclosures. In this notice, you are required to sign acknowledging that your information will be kept confidential, except as necessary or required by law. This office strives to maintain a high level of confidentiality at all times, and as such are compliant with the HIPAA privacy rules.

Insurance Information:
Most insurance policies do cover chiropractic care. If yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Freedom to choose your own health care provider is a fundamental right. We offer payment plans to those individuals without health insurance, if you find it necessary.

We will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to this office will be credited to your account upon receipt. **However, you must clearly understand and agree that all services rendered to you are charged directly to you, and that you are personally responsible for payment.**

In order to facilitate the correct and rapid processing of your insurance claim, we suggest you call your insurance agent to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy. Also, ask what percent of your claim will be paid by the insurance company. If you have questions, feel free to ask. We are experienced in insurance claims handling and will be glad to help in any way possible.

We will call your insurance provider for an explanation of your plan benefits. This is a general summary of the benefits available under your plan, and is not intended to be used as an authorization for services to be provided or a guarantee of benefits. Your specific plan exclusions and limitations will be applied at the time the claim is processed, which can be several weeks to a month or more. Your eligibility and benefits are based upon information currently available to us, and are subject to change without our prior notification. All benefits are subject to your plans pre-existing condition limitations as specified in the plan. All covered charges will be limited to reasonable and customary charges. Benefits may also be coordinated with another carrier is other coverage is involved. **Ultimately, this is your insurance and final responsibility is yours to assume.**

Co-payments are due at the time services are rendered.

PLEASE READ AND SIGN BELOW:

I understand and agree that health and accident 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. However, I clearly understand and agree that all services rendered 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 hereby authorize this office to examine and treat my condition as they deem appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. It is understood and agreed the amount paid to our office for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. I also agree that I am responsible for all bills incurred at this office, and that this office will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that I may obtain copies of my medical file and any x-rays taken upon request, and that copying fees may apply for these records.

In addition, my signature below acknowledges my Patient Consent for Use and Disclosure of Protected Health Information and that I have been offered a copy of the Chiropractic Healing Center's Notice of Privacy Practices. I have had an opportunity to ask questions regarding its content, and by signing agree to the policies mentioned within those documents.

Patient (or Parent\Legal Guardian's) **Signature**: _____ Date: ____/____/_____

Informed Consent to Chiropractic Adjustments and Care:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Harding, Dr. Loew and/or his/her preceptor and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for any doctor of the Chiropractic Healing Center.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Office Policies, including the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's **Printed** Name: _____

Patient (or Parent\Legal Guardian's) **Signature**: _____ Date: ____/____/_____

Assistant's Signature: _____ *Date:* ____/____/_____

Doctor's Signature: _____ *Date:* ____/____/_____

Our mission is to work together, synergistically through God,
to guide people to health chiropractically with love, enthusiasm and a smile.

Date: ___/___/___ Name (print):_____ D.O.B ___/___/___

PATIENT HISTORY FORM

Complaint 1 2 3 (please circle) _____

- **Please circle the number that best describe the complaint most of the time:**
  (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst)

- **What % of the time, you are awake, do you experience the above complaint at the above intensity?**
  0-25% 26-50% 51-75% 76-100%

- **Describe the quality of the complaint** (circle all that apply)
  sharp - dull - achy - burning - throbbing - numbness - stabbing - deep - nagging - shooting - tingling

  other (please describe):_____

- **When did the complaint begin?** (recent date) ___/___/___

  - Did it begin ***suddenly*** OR ***gradually***? (circle 1)

  - How did the complaint begin? _____

    _____

- **What makes the complaint worse?** (circle all that apply for this complaint)
  Neck: bending forward - bending backward - tilting head to left - tilting head to right - turning head to left - turning head to right

  bending at waist: forward - backward

  sitting - standing - getting up from sitting position - lifting - any movement - driving - walking - running - laying - computer work

  other (please describe): _____

- **What makes the complaint better?** (circle all that apply for this complaint)
  rest - ice - heat - stretching - exercise - massage - pain medication - muscle relaxers - nothing

  other (please describe):_____

- **Does the complaint radiate to another part of your body?** (circle one) ***YES*** ***NO***

  - If yes, where to?
    _____

- **Is the complaint worse at certain times of the day or night?** (circle all that apply)
  morning - afternoon - evening - night - unaffected by time of day

Date: ___/___/___ Name (print):_____ D.O.B ___/___/___

- **Have you ever had any tests performed for your current condition?** (circle one) ***YES*** ***NO***
  - If yes, when and by whom? ___/___/___ _____
    ___/___/___ _____
    ___/___/___ _____
- **Have you had any in/out patient procedures within the last 10 years?** (circle one) ***YES*** ***NO***
  - If yes, when, where and what? ___/___/___ _____
    ___/___/___ _____
    ___/___/___ _____
- **Have you been involved in accidents, slips, falls, etc. within the last 10 years?** (circle one) ***YES*** ***NO***
  - If yes, when and what? ___/___/___ _____
    ___/___/___ _____
    ___/___/___ _____
- **Please rate your stress level**
  (low) 0 1 2 3 4 5 6 7 8 9 10 (high)
- For **FEMALES** only:
  - Do you currently menstruate? **YES** **NO** last started ___/___/___
  - Are you pregnant? **YES** **NO** due date ___/___/___
  - Have you reached menopause? **YES** **NO** when ___/___/___

_____

_____

_____

_____

_____

PAST MEDICAL AND FAMILY HISTORY FORM

Patient Name: _____ Date: ___/___/___

DOB: ___/___/___

PLEASE CHECK IF YOU OR
ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING (**please specify who**):

Anemia	Self	Family member
Arthritis	Self	Family member
Atherosclerosis	Self	Family member
Cancer	Self	Family member
Cardiovascular disease	Self	Family member
Congenital anomaly	Self	Family member
Crohn's disease	Self	Family member
Diabetes mellitus	Self	Family member
Gastrointestinal disease	Self	Family member
Gout	Self	Family member
Hypercholesterolemia	Self	Family member
Hypertension	Self	Family member
Hyperthyroidism	Self	Family member
Hypothyroidism	Self	Family member
Ischemic heart disease	Self	Family member
leukemia	Self	Family member
Malignant melanoma	Self	Family member
Malignant neoplasm of lung	Self	Family member
Migraine	Self	Family member
Multiple sclerosis	Self	Family member
Neurological disorder	Self	Family member
Osteoporosis	Self	Family member
Polycystic ovaries	Self	Family member
Prostate cancer	Self	Family member
Rheumatoid arthritis	Self	Family member
Stroke	Self	Family member
Thalassemia	Self	Family member
Thyroid disorder	Self	Family member
Tuberculosis	Self	Family member

CHIROPRACTIC HEALING CENTER

Affordable OFF INSURANCE price guidelines:

Excludes Medicare patients due to Medicare guidelines.
All contractual obligations between our office and the insurance carrier must be followed.

Exam fee new patient	$10.00
Exam fee existent patient	$5.00

Adjustment fees	$40.00
Time of service discount	$35.00 (coupon + payment on the day of service are required)

Once you are out of the acute phase, you will be considered in the maintenance phase. Each patient responds differently, depending on your severity of condition, how long you have had the problem, and how well you follow your care plan will determine when the Doctor feels you are ready for maintenance.

Maintenance Fee $25.00

Once you are in maintenance care **and** *have attended the Dr.'s Report*, we would like to continue restoring a healthy nerve system and get you functioning at your maximum potential. We have a wonderful plan to make it affordable for you and your family to achieve this goal.

Life Enhancement Plan $81.00 per month, per person

$150.00 per month, per family of four (within the same household)
($25.00 additional per person within the same household)

This allows you and your family members to be adjusted once a week for the month.
Additional visits will be $ 25.00 per person.

If your case becomes active again due to an injury or flare up we will freeze your account. This program is designed for a lifetime of care, but there are no contractual obligations.

All Children 18 years and under will be $10 once they are in the wellness stage.

After delivering a baby, moms receive a free exam and adjustment within the first year after delivery.

All Children 1 year and under are Free.