

PATIENT APPLICATION

WELCOME TO OUR CLINIC! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far *superior results* compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature:

Today's Date:

File #:

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Cell Phone Provider: _____ May we contact you via text (no solicitations) regarding appointments? No Yes
Birth Date: ____ / ____ / ____ Social Security #: _____ - _____ - _____ Marital Status: S M D W
Occupation: _____ Employer Name: _____
Emergency Contact: _____ Phone: () _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
Names of Children: _____ Ages: _____
How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____
Is this purpose related to an auto accident / work injury? No Yes If so, when: _____
When did this condition begin? ____ / ____ / ____ Did it begin: Gradual Sudden Progressive over time
What activities aggravate your symptoms? _____
Is there anything, which has relieved your symptoms? No Yes Describe: _____
Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting
Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? Yes No
How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity
Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain: _____
Have you experienced this condition before? No Yes If so, please explain: _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? No Yes Who? _____ When? _____
Reason for visits: _____
How did you respond? _____
Did your previous chiropractor take before and after x-rays? No Yes
Did you know posture impacts your health? No Yes
Are you aware of any of your poor posture habits? No Yes
Explain: _____
Are you aware of any poor posture habits in your spouse or children? No Yes
Explain: _____
The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? No Yes
File Number: _____ Date: _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? No Yes How much/how long? _____

Do you drink alcohol? No Yes How much / week? _____

Do you drink coffee? No Yes How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? No Yes _____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Posture Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please CIRCLE any health condition you are currently experiencing, and CHECK any you have experienced in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Posture Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flue |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |

Explain: _____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Posture Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain On Deep Inspiration/Expiration |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Asthma/Wheezing | |

THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Posture Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience:

- | | | |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Ulcers/Gastritis | |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Posture Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Constipation / Diarrhea |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose (med name-purpose): _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

File Number: _____

Patient Name: _____

Date: _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to The Chiropractic Health and Wellness Center for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of The Chiropractic Health and Wellness Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below 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 the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below 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 conditions(s) for which I seek treatment.

Signature _____ Date _____
(If under age 18 Parent's signature)

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature _____ Date _____
(If under age 18 Parent's signature)

File Number: _____

Patient Name: _____

Date: _____

FINANCIAL AGREEMENT

I hereby authorize The Chiropractic Health and Wellness Center, LLC (CHWC) to furnish my insurance company(ies), my attorney(s), and any other legal representatives whom I may designate from time to time, with any records, reports, or other information those parties may request regarding my condition or my course of treatment.

I further hereby assign to CHWC all rights I may have to reimbursement from any insurance companies which do or may provide reimbursement or indemnification for the expenses I may incur from time to time at CHWC. I understand that CHWC may notify such third party payers of this assignment in order to arrange for direct payment by the payers to CHWC, but I further understand that any such arrangements shall be for the sole benefit of CHWC, and shall create no rights in my favor.

I understand that CHWC processes insurance claims as a courtesy to me, its patient, and not out of any obligation to do so. Under no circumstances shall CHWC's processing of any insurance claims be construed as imposing upon CHWC any obligations to continue pursuing such claims when denied or lost by my insurer, nor to excuse any charges questioned or denied in whole or in part by my insurer. I understand that I remain personally responsible to CHWC for all charges incurred by me, and that ultimately, the responsibility for securing payment from any third party payers, such as insurance companies, is mine alone.

Upon failure by me to pay any charges insured within thirty days of the date the charges are posted to my account, I shall be deemed to be in default of this Financial Agreement. Upon a default, interest shall begin to accrue upon all charges posted to my account at the rate of 1.75% per month (21.00% per annum), compounded monthly. Should CHWC, in its sole discretion, elect to place my account into the hands of an attorney or third party collection agent, I shall become further liable for all costs of collecting including but not limited to collection agency or attorney's fees of up to 38% of the total account balance due.

I may execute and deliver a copy of this Financial Agreement by facsimile or another means of reproduction, and I authorize CHWC and any court of competent jurisdiction to rely upon a true copy of my signature in lieu of an original.

Patient Signature: _____ Date: _____

Patient Name (please print): _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement and Consent

Acknowledgement and Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by The Chiropractic Health and Wellness Center, LLC 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 for a more complete description of how your Protected Health Information 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. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

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

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

Revocation of Consent

You may revoke consent to the use or 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 my permission to use and disclose my health information.

_____ I **HAVE NOT** requested a/an

- Restriction of Consent on the Use or Disclosure of my Protected Health Information
- Method of Alternative Communications
- Objection to the Notice of Privacy Practices

_____ I **HAVE** requested a/an

- Restriction of Consent on the Use or Disclosure of my Protected Health Information
- Method of Alternative Communications
- Objection to the Notice of Privacy Practices

Signature: _____ Date: _____

Print Name: _____ Date: _____

Witness: _____ Date: _____