

Welcome to Action Chiropractic

Patient Information

Today's Date: _____
 Patient's Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Cell Phone: _____
 Email Address: _____
 Birth Date: _____
 Patient SS#: _____
 Who is responsible for this account? _____
 Health Insurance Company: _____
 Policy Holder Name? _____
 Do you have an Health Savings Account (HSA) or a Flex
 spending account? ☐ Yes ☐ No

In Case of Emergency, Contact:

Name: _____
 Relationship: _____
 Contact Number: _____

I give Action Chiropractic permission to contact me at the above number and/or email, as well as, text me appointment reminders, and leave messages.

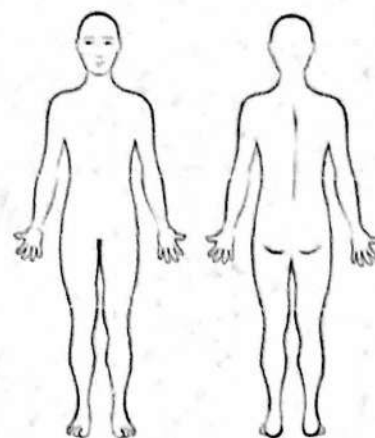
X _____
Signature

☐ Check if you would like opt OUT of the text reminders

Patient's Current Condition (please answer all 10 questions and mark the picture)

- 1) Reason for treatment (eg. Back pain, Headaches, Carpal tunnel):? _____
- 2) When did your pain begin (eg. 5 years ago, 2 weeks ago, yesterday):? _____
 If it began years ago, when did it most recently flare-up (eg yesterday, a week ago): _____
- 3) Is your pain from an accident/fall (eg. Auto, Work, Home)? _____
- 4) Is your condition becoming: ☐ Better ☐ Worse ☐ Staying the Same
- 5) On a scale 0 through 10, how **HIGH** does your pain become (circle #):
 (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
- 6) On a scale 0 through 10, how **LOW** does your pain drop to (circle #):
 (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
- 7) Type of pain (circle): Sharp Dull Achy Throbbing Burning Shooting
 Numbness Tingling Cramping Stiffness Stabbing
 Other: _____
- 8) My pain is (circle): Constant or Comes and Goes
- 9) My pain makes it difficult to (circle): Sit Stand Walk Bend Lay Down
 Drive Climb Stairs Sleep Work
 Daily activities Recreation
- 10) My pain reduces when I (circle): Sit Stand Walk Lie down Rest
 Use Heat Use Ice
 Take Advil/Aleve/Ibuprofen/Pain Meds

Mark on the picture where
you have pain



Patient Health History

What treatment have you already received for this condition? ☐ Medication ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other Doctors that have treated you for this condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Tumors/growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disease	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infection	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid		Other _____	
Chemical				Arthritis	☐ Yes ☐ No	_____	
Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	_____	
Chicken Pox	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	_____	

Exercise	Sleep	Work Activity	Habits					
☐ None	☐ Hours per night	☐ Sitting	☐ Smoking	Packs/Day				
☐ Moderate		☐ Standing	☐ Alcohol	Drinks/Week				
☐ Daily		☐ Light Labor	☐ Coffee/Caffeine	Cups/Day				
☐ Heavy		☐ Heavy Labor	☐ Stress:	Mild	Moderate	Severe	Extreme	

The majority of your day is spent: Seated Standing Walking

Women Only: Are you pregnant? ☐ Yes ☐ No **Due Date:** _____

Family Medical History: ☐ Diabetes ☐ Heart ☐ Stroke ☐ Cancer ☐ Blood pressure problems ☐ Other

Injuries/Surgeries you have had	Description	Date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone _____		

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 if there is anything that is unclear.

Financial Arrangement

PRIVATE PAY:

In order to qualify for cash prices, payment is due at the time of treatment. If a patient cannot pay at the time of service they are expected to pay regular fees, as set by insurance carriers, and this office.

THIRD PARTY PAYERS:

Note: Insurance is an agreement between the patient and the insurance company. Not the Doctor. Treatment will be set according to the patient's needs not by who will be paying for services rendered.

INSURANCE:

If you have insurance that covers Chiropractic care, Action Chiropractic would be glad to fill out all paperwork regarding your condition and treatment. We will file directly for payment of services rendered each week, for you, after verbal verification of your coverage for your insurance carrier. As the patient you will be responsible for any fees or services not covered by your insurance policy. Any co-pay or deductible will be paid at the time of service.

AUTOMOBILE INSURANCE:

If you have been in an automobile accident and would like to file with automobile insurance Action Chiropractic will be happy to deal directly with the insurance company provided they would accept an assignment of benefits. An assignment of benefits indicates that the insurance company will make payments directly to Action Chiropractic for the services rendered and billed out.

WORKMANS COMPENSATION:

In order for your workmen's compensation claim to be valid we must have verbal as well as written authorization for treatment from your employer as well as verbal authorization for treatment from your employer's workmen's compensation carrier. A member of this office will do this during your first visit.

If you have any questions regarding our policies listed above please ask our front staff. This person will assist you in filling out any forms as well as explain payment arrangements that are in line with Action Chiropractic financial arrangement.

I have read and fully understand and agree to abide by Action Chiropractic's financial arrangement policies that pertain to me. I furthermore acknowledge and agree that I am responsible for paying Action Chiropractic fee for treating me and at any time, Action Chiropractic can demand that I pay for all or part of the balance of said fee. I also agree to pay all of Action Chiropractic expenses to collect said fees, including a reasonable attorney fee.

Authorization and Assignment

In consideration of treatment, I agree to the following:

1. You (Action Chiropractic) are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred to me.
2. I authorize to direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any or otherwise obligated to make payment to me based in whole or in part upon the charges made for your service.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of the action that exists in my favor against such company and authorize you to prosecute said action either in my name or your name as you see fit. However, it is understood that I remain fully responsible for any amount due on my account regardless of the circumstance.

4. I agree to make full payment to Action Chiropractic at the time of services rendered unless other arrangements are made in advance of treatment.
5. If any amount is billed to me on a monthly statement, I agree to pay the full amount due by the first day of the following month. I also understand that if I fail to make full payment, a 10% interest charge will be added to my total balance and is due immediately.
6. In the event that payment is not made and further action is necessary to enforce payment, I agree to pay any and all collection cost, court costs, and reasonable attorney fees required to collect the amount due on my account.

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information (PHI)

Your Protected Health Information will be used by Action Chiropractic or may be disclosed to others for the purposes 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. A copy of the Notice of Patient Privacy is located in the lobby, and you are free to review it. If you cannot find the document or have questions, please ask for it from the receptionist, or the doctor.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction 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.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

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.

Informed Consent

The nature of the chiropractic adjustment

The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may also feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: Spinal Manipulative therapy, adjunctive therapies, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, isometric stretches.

The material risks inherent in the chiropractic adjustment

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor. At anytime in the future you are diagnosed with a condition that may affect your care it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for you condition may include: Self- administered, over-the-counter analgesics and rest, medical care and prescription drugs, hospitalization, and/or surgery. If you choose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with you primary medical physician

The risks and dangers of avoiding treatment

Remaining untreated may allow the formation of adhesions and reduce 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.

X-ray Patient Consent

This is to certify, that to the best of my knowledge, I am not pregnant, and Action Chiropractic has my permission to perform a diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

PATIENT USE

I have read and fully understand, and agree to abide by Action Chiropractic's:

Financial Arrangement (page 3): Yes / No

Authorization of Assignment (page 3): Yes / No

Consent to use PHI (page 4): Yes / No

Informed Consent (page 4): Yes / No

X-ray Consent (page 5): Yes / No

I furthermore acknowledge and agree that I am responsible for paying Action Chiropractic their fee for treating me and at any time, Action Chiropractic can demand that I pay for all or part of the balance of said fee. I also agree to pay all of Action Chiropractic expenses to collect said fees, including a reasonable attorney fee.

Patient's Written Name

Patient's Signature

Date