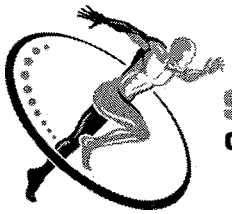


SPINE & SPORTS
CHIROPRACTIC

# Informed Consent for Chiropractic Care

I hereby authorize the performance of diagnostic tests, procedures and treatment deemed necessary by my Doctor of Chiropractic or other personnel involved in my care.

I acknowledge that I have read and understand the following: Doctors of Chiropractic using manual therapy treatments for patients with headache and cervical spine (neck) complaints are required to explain that there have been rare case of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 out of 400,000 treatments to 1 out of 10 million treatments. As with any health procedure, complications may arise during treatment. These complications include muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Chiropractic adjustments, Active Release Technique, and other manual therapies have few if any risks associated for the vast majority of patients. Most risks are minimal such as soreness and bruising.

I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee as may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health facility. If I fail to pay charges incurred, any outstanding debt will be submitted to a collection agency until pain in full.

I am aware that I am financially responsible for a **NO SHOW FEE** if I do not notify Spine and Sports Chiropractic **4** hours prior to a missed appointment. **First time NO SHOWS will result in a $25 charge to my account. Any further late notifications or missed appointments will be increased to $55.**

I intend for this consent to apply to all my present and future chiropractic care.

**Date**: _____

**Patient Name (please print)**: _____

**Patient Signature**: _____
(Parent/Guardian if under 18)

SPINE & SPORTS CHIROPRACTIC

# Patient Registration

## Patient Information

Name (Last, First):_____ SS#:_____

Mailing Address:_____ City:_____ State:____ Zip Code:_____

Preferred Phone:_____ Home Phone:_____ Cell Phone:_____

Date of Birth: ___/___/___ Marital Status: Single Married Divorced Widowed

Email Address:_____

Gender: Male/ Female Preferred Language:_____

Race (circle one): American Indian or Alaska Native/ Asian/ Black or African American/ White (Caucasian)/ Native Hawaiian or Pacific Islander/ Other/ I Decline to Answer

Ethnicity (circle one): Hispanic or Latino/ Not Hispanic or Latino/ I Decline to Answer

Smoking Status: (circle one): Everyday smoker/ Occasional Smoker/ Former Smoker/ Never Smoked

Emergency Contact/ Parent Name:_____ Phone:_____

How did you hear about our office?:_____

What form of insurance will we be billing for you? ☐ Personal ☐ Worker's Comp ☐ Automobile ☐ Medicare ☐ None

☐ I Choose to Decline receipt of my clinical summary after every visit
*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

## HIPAA Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information will be used to: 1) conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, 2) obtain payment from third-party payers, and 3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy'.

Signature:_____ Date:_____

Relationship to patient (if under 18):_____

Updated and reviewed by: Date:_____ Initial_____ Doctor:_____

# Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name:** _____ DOB: / / **Date:** _____

***1. When did your symptoms start:*** _____ ***Describe your symptoms and how they began:***

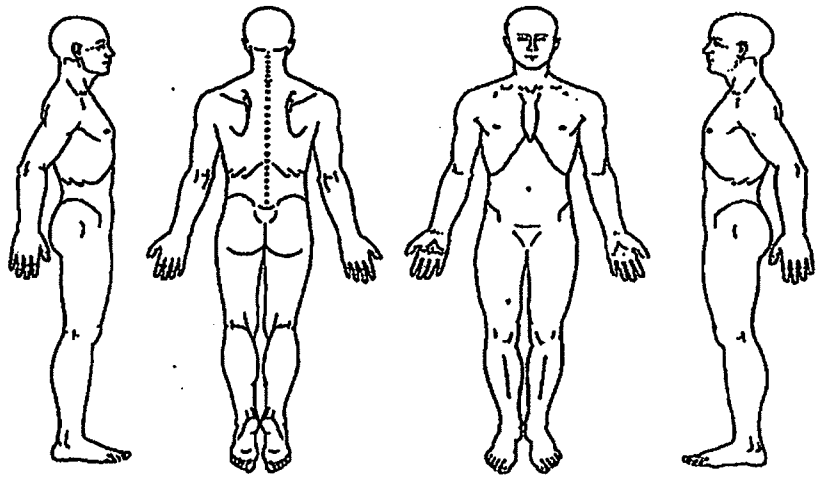
_____

_____

***2. How often do you experience your symptoms?***

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

***Indicate where you have pain or other symptoms:***



***3. What describes the nature of your symptoms?***

- ☐ Sharp ☐ Shooting ☐ Weak
- ☐ Dull ache ☐ Burning ☐ Tightness
- ☐ Numb ☐ Tingling ☐ _____

***4. How are your symptoms changing?***

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

***5. How bad are your symptoms at their:***

| | None | | | | | | | | | | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***a. worst:*** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| ***b. best:*** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

***6. How do your symptoms affect your ability to perform daily activities?***

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|
| *No complaints* | | *Mild, forgotten with activity* | | *Moderate, interferes with activity* | | *Limiting, prevents full activity* | | *Intense, preoccupied with seeking relief* | | *Severe, no activity possible* |

***7. What activities make your symptoms worse?:*** _____

***8. What activities make your symptoms better?:*** _____

***9. Who have you seen for your symptoms?***

- ☐ No One ☐ Medical Doctor ☐ Other
- ☐ Other Chiropractor ☐ Physical Therapist

*a. When and what treatment?* _____

*b. What tests have you had for your symptoms and when were they performed?*

- ☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
- ☐ MRI *date:* _____ ☐ Other *date:* _____

***10. Have you had similar symptoms in the past?*** ☐ Yes ☐ No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

- ☐ This Office ☐ Medical Doctor ☐ Other
- ☐ Other Chiropractor ☐ Physical Therapist

***11. What is your occupation?***

_____

- ☐ Professional/Executive ☐ Laborer ☐ Retired
- ☐ White Collar/Secretarial ☐ Homemaker ☐ Other
- ☐ Tradesperson ☐ FT Student

*a. If you are not retired, a homemaker, or a student, what is your current work status?*

- ☐ Full-time ☐ Self-employed ☐ Off work
- ☐ Part-time ☐ Unemployed ☐ Other

***12. What do you hope to get from your visit/treatment (select all that apply)?:***

- ☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
- ☐ Resume/Increase activity ☐ Learn how to take care of this on my own ☐ Other