File #_____

Patient Information and History

PATIENT INFORMATION

Name:

Who referred you here?

Address:

City: State: Zip:

Birthdate: / / Age: ☐ Male ☐ Female

Social Security # / /

Occupation:

Employer:

Parents Name (If minor):

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name:

# of Children: Name(s):

INSURANCE INFORMATION

Are we checking your insurance? ☐ Yes ☐ No

Did we take a copy of your ins card? ☐ Yes ☐ No

Who is the policy holder?

Policy holder's birthdate:

CONTACT INFORMATION

Home Phone:

Cell Phone:

Work Phone:

Email:

Preferred contact method:

IN CASE OF EMERGENCY, CONTACT:

Name: Relationship:

Home Phone: Cell:

ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date of accident: Time:

Type of Accident? ☐ Automobile ☐ Workers Comp ☐ Home ☐ Other:

To whom have you reported the accident? ☐ Insurance ☐ Worker's Comp ☐ Employer

If this is due to a workers comp injury, are you employed full time or part time?

Insurance Co: Policy # Claim #

Adjuster's Name Phone #

Do you have an attorney? ☐ Yes ☐ No If yes, who?

Please describe the accident:

PATIENT CONDITION

What is your major symptom/problem?

When did your symptoms begin?

Have you had this problem before?

Is your condition getting progressively worse?

Is this problem ☐ Constant ☐ Comes & Goes

How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull

☐ Ache ☐ Stiff ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other

Circle below the severity of your pain on a scale from 0-10

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better?

What makes your condition worse?

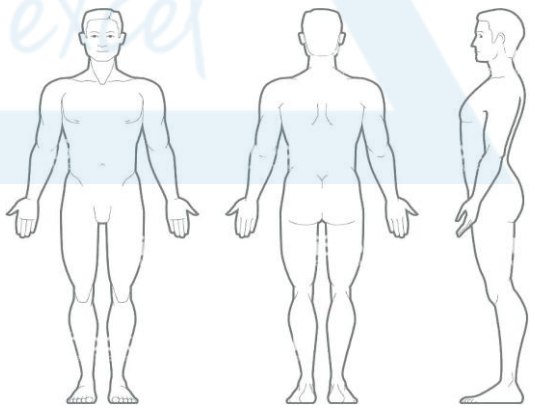
Does it interfere with: ☐ Work ☐ Sleep ☐ Routine ☐ Recreation

Activities/movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

☐ Driving ☐ Other:

Please mark where it hurts:



File #_____

HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition: _____

Describe the other doctors' treatment for your condition: _____

Previous chiropractic care? ☐ No ☐ Yes Date: _____ ☐ Local ☐ Out of State _____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ MRI: _____

Spinal Exam: _____ Dental X-Ray: _____ CT Scan: _____

List any medications you are taking along with their dosage: _____

Vitamins / Herbs / Minerals: _____

Females: Are you pregnant? ☐ Yes ☐ No Beginning of last menstrual cycle: _____

Check any of the conditions you have had:

☐ AIDS / HIV	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Allergies	☐ Digestion Problems	☐ Insomnia	☐ Sciatica
☐ Anxiety / Depression	☐ Earache	☐ Irregular Cycle	☐ Sinus Infection
☐ Arm/Shoulder Pain	☐ Ear Ringing	☐ Kidney Problems	☐ Stroke
☐ Arthritis	☐ Epilepsy	☐ Leg Pain	☐ Thyroid Problems
☐ Asthma	☐ Headaches	☐ Low Back Pain	☐ TMJ
☐ Bladder Problems	☐ Headaches - Migraines	☐ Neck Pain	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Osteoporosis	☐ Vertigo / Dizziness
☐ Chronic Fatigue	☐ Hemorrhoids	☐ Poor Circulation	
☐ Deafness	☐ Herniated Disk(s)	☐ Prostate Problems	

STRESSORS

☐ Smoking Packs/day: _____

☐ Alcohol Drinks/week: _____

☐ Coffee/Caffeine Cups/day: _____

☐ High Stress Level Reason:

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

Have you had any:	Description	Date
Automobile Accidents		
Surgeries		
Broken Bones		
Falls / Head Injuries		

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Finish Line Chiropractic to release any information regarding my treatment to any insurance company in an effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature (of parent if patient is a minor) Date

File # _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment we must require you to read and sign this consent form, stating that you understand and agree with how your record will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

5. For your security and rights privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

_____ _____

Signature Date

File # _____

PROFESSIONAL FEE SCHEDULE

INITIAL VISIT AND STANDARD VISITS

Consultation	No Charge
Examination	$60 - $140
X-Rays (per view)	$60
Office Visit, Adjustment	$35-$55
Extremity Adjustment	$55
Therapies	$35

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can.

PLAN 1: GROUP INSURANCE

If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment, do not pay for maintenance care, and ordinarily are designed and intended to only take care of acute problems. Please understand that insurance companies have cost containment programs to reduce the amount of claims paid even when the patient's care is justified.

PLAN 2: CASH

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN 3: HEALTH CARE MADE AFFORDABLE (HCMA)

For those patients who qualify, we offer discounted cash agreements on a monthly and block basis.

PLAN 4: WORKER'S COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

Insurance verification and authorization is not a guarantee of payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Finish Line Chiropractic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided.

I have read and understand all of the options available to me.

_____ _____ _____

Signature *Date* *Parent/Guardian signature (if minor)*

File #_____

INFORMED CONSENT

PATIENT NAME: _____
(Please Print)

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.

The nature of the chiropractic adjustment:
The primary treatment we use as 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 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, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, and/or radiographic studies.

The material risks inherent in 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. We 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 our attention, it is your responsibility to inform your 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 an X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:
Other treatment options for your condition may include:

- Self administered, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- 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 your primary medical physician.

The risks and dangers attendant to remaining untreated:
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.

If you are pregnant or think you may be pregnant, please inform the doctor at once.

File #_____

The doctor may request that we perform an x-ray to obtain additional information:
X-Ray produces images of the internal body parts being examined. X-Ray is painless, however, radiation is emitted. X-Ray can cause harm to an unborn child. Radiation exposure can cause cell mutations that may lead to cancer. The amount of radiation you're exposed to during an X-Ray depends on the tissue or organ being examined. Therefore, it is critical for you to inform our personnel if there is any possibility you could be pregnant. Because the X-Ray is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the X-Ray, accurate diagnosis and proper treatment may be delayed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Patient's Name (Printed) Doctor's Name (Printed)

_____ _____
Patient's Signature (Parent/Guardian if Minor) Doctor's Signature

_____ _____
Date Date