CONNECT CHIROPRACTIC

Information About You

Name _____ Date_____

Address_____City_____

State_____ Zip Code_____ Phone _____

Email_____

Birth Date_____ Age_____ Sex_____ Weight_____ Height _____

Marital Status: Married Single Widowed Divorced Separated # of Children_____

Employer_____

Type of Work_____

Emergency Contact_____ Phone_____ Relationship_____

How did you hear about us? Live Nearby Community Outreach Event Spinal Screening
Google Social Media Referral
Other_____

What brings you to the office?_____

Has anyone else in the family experienced these symptoms? YES NO

When did these symptoms begin? _____

Have you had these symptoms before? YES NO

If Yes, explain _____

How frequently does this occur? CONSTANT FREQUENT INTERMITTENT OCCASIONAL

Does it occur at certain times of the day? MORNING AFTERNOON EVENING

Does this condition interfere with WORK SLEEP DAILY ROUTINE HOME LIFE N/A

Have you seen another physician for these symptoms? NO YES, Whom? _____

Type of treatment_____

Results _____

Responsible Party: If Other than the Patient, Please Complete (should match the person signing the consent for treatment form)

Name_____ Relationship to Patient _____

Address, if other than same _____

Home Phone (___)_____ Work Phone (___)_____ Social Security # _____

Responsible Party's Birthdate _____ Employer Name & Address _____

Insurance Information:

Primary Insurance Company_____ Phone # (____)_____ Contract #_____

Subscriber Name_____ Date of Birth _____Social Security #_____

Group # _____ Address if different _____

Secondary Insurance Company_____Phone # (____)_____ Contract #_____

Subscriber Name_____ Date of Birth _____Social Security #_____

Group # _____Address if different _____

Financial Responsibility Statement/ Release of Information Authorization

I authorize Connect Chiropractic & Lakeshore Medical Billing, LLC to contact my employer and my insurance company in order to verify insurance benefits. I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Provider for services received. I also authorize the release of information to listed physicians and/ or individuals.

X_____ Date _____
Signature of Patient or Legal Guardian

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my provider and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.

X_____ Date _____
Signature of Patient or Legal Guardian

Patient Health History

Experienced any of the following?
Appendectomy Tonsillectomy Gallbladder Removal Hernia Back/Neck injuries Surgery
Broken Bone Car Accident Major Fall/injury Concussion
Others_____
Please Explain_____
Hospitalizations_____
Name of Primary Physician_____
Last Chiropractor Seen_____
Date of last Chiropractic Visit_____

Circle All that Apply

Acute Phlebitis	Diagnosed Emotional/Mental	Nausea
Allergies	Dizziness	Neck Pain/Stiffness
Alcoholism	Difficulty Breathing	Nosebleeds
Anemia	Epilepsy	Numbness
Arteriosclerosis	Excessive Menstruation	Pacemaker
Arrhythmia's	Eye Pain or Difficulties	Parkinson's
Arthritis	Fatigue	Polio
Asthma	Foot Pain	Poor Circulation
Autoimmune Disease	Frequent Urination	Poor Posture
Back Pain	Gallbladder disease/stones	Prostate Trouble
Bed Wetting	Glaucoma	Plugged Ears

Bleeding Disorders	Gout	Raynaud's Phenomenon
Blood Clots	Headache	Retinal Disease
Breast Lump	Heartache	Sciatica
Bronchitis	Hemorrhoids	Seizures
Bruise Easily	High Blood Pressure	Shortness of Breath
Bursitis	Hot Flashes	Sinus Infection
Cancer	Infection	Slow Heartbeat
Cataracts	Irregular Heart Beat	Sleep Problems/Insomnia
Chest Pain	Irregular Menstrual Cycle	Skin Sensitivity
CHF (congestive heart disease)	Kidney Infection	Smoke
Cold Extremities	Kidney Stones	Spinal Curvatures
Colon Problems	Liver Disease/Cirrhosis	Stroke
Constipation	Loss of Memory	Swelling of Ankles
COPD/Emphysema	Loss of Balance	Swollen Joints
Cramps	Loss of Smell	Thyroid Condition
CVA (stroke/TIA)	Loss of Sleep	Thrombophlebitis
Deafness	Loss of Taste	Tuberculosis
Dementia/Alzheimer's	Low Blood Pressure	Ulcers
Depression	Lung disease	Varicose Veins
Detached Retina	Lung Puncture	Venereal Disease
Diabetes	Macular Degeneration	Vision Loss
Digestion Problems	Migraines	Other

Family History - Check All That Apply

Cancer	Hypoglycemia	Parkinson's
Heart Disease	Osteoporosis	Suicide
Diabetes	Alzheimer's	High Blood Pressure

Other health conditions of parents siblings or grandparents_____

_____

Office Policies: If I am accepted as a patient at this office (Connect Chiropractic LLC), I agree to pay for all services, including services not covered by my insurance company, at time of service. I also acknowledge, that when I am given explanation of my benefits from the practice, it is not a guarantee of payment. If I suspend (or terminate) my treatment at any time, a note will be made in my file with reasons cited. I then agree to be fully responsible for my condition of care. I understand that no special promotions can be combined with the use of insurance.

Chiropractic Care: For over 100 years, chiropractors have been helping others reach their optimal level of health without drugs or surgery. By reducing nerve interference and tension due to spinal misalignments (subluxations), chiropractic care enhances the body's ability to heal and function at it's optimal level. As proper function is restored, health returns and symptoms usually subside.

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that this office has the right to change its Notice of Privacy Policies, and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Policies. I also understand that I may withdraw my consent in writing.

I give this office, consent to contact me in the following ways. Please mark and fill out the permitted ways to contact you. If unavailable, please indicate if we can leave a message.

Phone number if different from already listed _____Message Yes/No Text Yes/No
Initial_____ Date_____

Authorization to Discuss Medical Information

I hereby authorize Connect Chiropractic, LLC to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specified information to be discussed:

- ☐ Appointment Dates/Times
- ☐ Diagnosis
- ☐ X-Ray Results
- ☐ Medications
- ☐ Lab Tests/Results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ Other (specify): _____

Information to be given to:

Name: _____ Address: _____

Relationship: _____ Phone: _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving Connect Chiropractic, LLC the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

Signature: _____Date: _____

Cancellation Policy

When a patient doesn't make it to a scheduled appointment, this is time another patient could have taken to receive the care they need. Please help us deliver the care our patients need as efficiently as possible.

If you need to cancel a Chiropractic appointment, please call us as soon as possible, so we have the opportunity to offer your appointment to another patient. If less than 24 hours notice is given, you will be charged a $36 cancellation fee.

If you do not show up for a scheduled appointment, you will be charged a $36 no show fee.

If you arrive late to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.

Multiple instances of not showing up for an appointment without canceling or rescheduling may result in the patient being dismissed from the practice.

I understand the terms of this policy. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company. The fee will be collected on a voluntary basis.

Print Name: _____ Patient's Signature: _____

Date: _____ Parent's Signature (if patient is a minor): _____

Informed Consent

I hereby request and consent to appropriate chiropractic case management for me (or for the person named below, for whom I am legally responsible) in this office. The following points have been explained to me.

1. The purpose of chiropractic care is to optimize health by facilitating neurological and biochemical integrity, which allows maximum expression of the body's innate recuperative abilities.
2. I understand that chiropractic services will be provided by a licensed Doctor of Chiropractic
3. The appropriate techniques will be selected for my care based on professional protocols. The proposed procedures will only be implemented with my approval. Alternative and adjunct recommendations for health promotions will be discussed with me.
4. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain every risk and complication, but I will rely on the doctor's best judgement to protect my best interests. No guarantees of cure have been implied or given.
5. A small force is introduced into the spine during a chiropractic adjustment that may lead to temporary musculoskeletal discomfort. This is usually minor and transient.
6. The doctor will discuss any further risks inherent for my particular case during a report of findings and will document this discussion in the case record. Any questions or concerns that I may have will be

addressed at this time. I understand that I am an active participant in my chiropractic care, and that I am encouraged to bring up questions or express any concerns.

7. I give my permission to the doctor to communicate by telephone or email regarding matters of chiropractic care, appointment reminders or scheduling.
8. This office will comply with all HIPAA regulations and take all reasonable precautions to safeguard your privacy in all matters. I understand that any concern I have regarding privacy and safety of my health information may be discussed with my doctor.
9. I understand that the clinical data may be anonymously used for research purposes. If this is done, I will be informed as to the nature of the research, and I will be given reasonable time to consider. I also understand that if I agree my personal information will not in any manner be identifiable.
10. I am free to refuse care or withdraw my consent and discontinue care at any time
11. I now authorize the doctor to proceed with any necessary treatments. By signing below, I affirm that I understand the office policies and informed consent information, and I agree to their provisions. I intend this document to cover the entire course of care, now and in the future.

Signature_____ Date_____