PRECISION CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Date:_____

Miss Mrs. Ms. Mr. Dr. First:_____ MI:____ Last: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Birthdate: _____

Social Security No. _____ Email Address: _____

Sex: **M F** Marital Status: **S M D W** Spouse Name: _____

Of Children: _____ Name/Age of Children: _____

Family Physician: _____ Phone: _____ Last Visit:_____

Physician Address: _____

Occupation: _____ Employer:_____

Insurance Carrier: _____ Policy No. _____

Referred by: _____

Reason for Visit: _____

Have you ever received chiropractic care? **Y N** If so, when? _____

The statements made on this form are accurate and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes. I agree to allow this office to examine me for further evaluation. I authorize the use of this signature on any insurance claim submissions made by **Precision Chiropractic.** *I fully understand that I am financially responsible to* **Precision Chiropractic** *for any fees including recovery fees not covered by my insurance carrier. I understand payment in full is required for all services rendered at the time of the visit.*

Patient/Guardian Signature: _____ **Date:** _____

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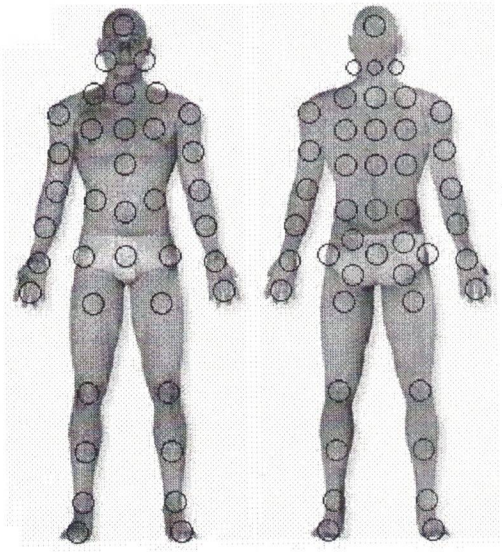
Patient Name _____ **Date**_____

Where is your discomfort? *(All that apply)*



Current Complaint:

No Pain Unbearable Pain

1 2 3 4 5 6 7 8 9 10

How often do you feel the pain? _____% of day

Mark below, on the line, how bad is the discomfort at its Worst and Best? (Mark B for at best and W for worst)

No Discomfort Unbearable Discomfort

1 2 3 4 5 6 7 8 9 10

Did the pain begin gradually or suddenly? *(circle one)*: gradual sudden

When did the discomfort begin? _____

Since the problem began, have the symptoms been getting better, worse or have they been relatively unchanged? *(circle one)*

better worse the same

What aggravates the discomfort? *(check all that apply)*

___ bending
___ bowling
___ carrying
___ cleaning
___ climbing
___ cooking
___ coughing
___ crawling
___ cycling
___ dressing
___ driving
___ eating
___ exercising
___ gardening
___ jumping
___ kneeling
___ lifting
___ lying
___ medications
___ playing golf
___ playing tennis
___ pulling
___ pushing
___ reaching
___ resting
___ running
___ sex
___ sitting
___ sleeping
___ sliding
___ sneezing
___ standing
___ stooping
___ swinging
___ turning
___ twisting
___ typing
___ walking
___ working

What relieves the discomfort? _____

_____

What is the quality of the discomfort? *(check all that apply)*

___ aching
___ anguish
___ burning
___ continuous
___ deep
___ depression
___ despair
___ discomfort
___ dull
___ frequent
___ insidious
___ intense
___ intermittent
___ malaise
___ melancholy
___ mild
___ moderate
___ numb
___ numbness
___ occasional
___ pain
___ random
___ severe
___ self-loathing
___ sharp
___ shooting
___ superficial
___ throbbing
___ tingling
___ tightness

When is the discomfort at its worst? ___ in the morning ___in the afternoon___ in the evening
___ just before bed ___ while sleeping

Which problems have you had in the past? *(check all that apply)*

___ HIV/AIDS
___ alcoholism
___ anemia
___ anorexia
___ appendicitis
___ arthritis
___ asthma
___ bleeding disorder
___ autoimmune problems
___ blood pressure
___ cancer
___ depression
___ diabetes
___ emphysema
___ epilepsy
___ fractures
___ heart disease
___ hernia
___ herniated disc
___ high cholesterol
___ kidney disease
___ liver disease
___ migraine headache
___ miscarriage
___ multiple sclerosis
___ osteoporosis
___ pacemaker
___ Parkinson's disease
___ pinched nerve
___ pneumonia
___ polio
___ prostate problems
___ psychiatric problems
___ rheumatoid arthritis
___ stroke
___ suicide attempt
___ thyroid problems
___ tumor growth
___ ulcers
___ vaginal infections
___ whiplash
___ bulimia
___ chemical dependency
___ hepatitis
___ venereal disease
___ gall bladder

Are you currently having any other symptoms in your body?*(check all that apply)*

___ eyes
___ right eye
___ left eye
___ ears
___ right ear
___ sinuses
___ nose
___ tonsils
___ throat
___ lungs
___ heart
___ chest
___ liver
___ right kidney
___ pancreas
___ left kidney
___ spleen
___ stomach
___ bowels
___ bladder
___ penis
___ prostate
___ testicles
___ vagina
___ ovaries
___ rectum

Please list any medications you are on now or have been on in the past:

_____

_____

_____

Please list any surgeries you have had:

_____

_____

_____

Please list any allergies you have: _____

_____

_____

PRECISION
CHIROPRACTIC

330-A E 5th North St., Summerville, SC 29483

843-376-7024

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Precision Chiropractic Center to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Precision Chiropractic (PC) to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If PC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to PC to use my name on a welcome board, referral board, and birthday board.
- I give permission to PC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to PC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give PC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form, you are giving Precision Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Precision Chiropractic plus 7 years or until revoked by me.

(over)

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Precision Chiropractic**- The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION; The
date of your request; and Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Precision Chiropractic for its own use/disclosure of PHI- (Minimum necessary' standards apply.)

I have the right to sign this AUTHORIZATION. If l refuse to sign this AUTHORIZATION, Precision Chiropractic will not refuse to provide treatment however, it will not be possible for Precision Chiropractic to file third party billing on my behalf and I will be responsible for l) Payment in full at the time services are provided to me 2) scheduling my own appointments since Precision Chiropractic will be unable to contact me 3) all contact with Precision Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____

Patient's name (please print):_____

Patient's Signature:_____

Today's Date:_____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____

_____

PRECISION
CHIROPRACTIC

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

PRECISION CHIROPRACTIC

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ _____
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____
Remarks: