Welcome to Care Chiropractic, P.C.

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

BIRTHDATE_____/_____/_____

†Minor † Single † Married † Widowed† Partnered†

Occupation_____ Employer_____

CONTACT PREFERENCES (CELL, HOME, WORK, ETC.)

PHONE 1_____

PHONE 2_____

EMAIL_____**@**_____

May we send you text or email reminders for your appointments?

If yes, provide cell carrier _____

Or reminder email_____@_____

May we send you statements via email? Y N

Please do not hesitate to ask about fees. We will file insurance claims at no charge

REFERRAL

How did you hear about us? _____

EMERGENCY CONTACT

NAME_____

PHONE NUMBER_____

INSURANCE INFORMATION (IF YOU ARE NOT THE POLICY HOLDER)

Please provide your ID and insurance cards for scanning.

Policy Holder Name_____

Address_____

Birthdate_____ Relationship to Patient_____

Is there a secondary insurance?

Policy Holder Name_____

Birthdate_____ Relationship to Patient_____

***Is your visit today related to an accident or work injury? Y N**

*Additional paperwork and accident insurance will need to be billed for **injury/accident claims**.*

Treatment for **Work injuries** need to be authorized by your employer to protect your rights.

You are responsible for any balance not paid by your insurance company.

IF NO INSURANCE: Payment is due when treatment is given.

INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service or at the end of each month. It is your responsibility to provide us with the proper insurance card. If you discontinue treatment, any charges are immediately due and payable.

TREATMENT PERMISSION: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. A service fee of $5.00 per month will be charged on any balance over 60 days old. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent me by Care Chiropractic, P.C. shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Care Chiropractic P.C. to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Care Chiropractic P.C. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Care Chiropractic P.C. pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: If any insurance company or third party may be obligated to pay to me or to Care Chiropractic P.C. for charges for services, refuses to make such payment upon demand, I assign, transfer, and convey to Care Chiropractic P.C. the cause of action that may exist in my favor against such company or person. I authorize Care Chiropractic P.C. to prosecute said action either in my name or their name to collect fees due for care rendered at Care Chiropractic P.C. for legal expenses and to resolve said claims as they see fit.

AUTHORIZATION TO PROCESS DRAFTS: I agree that Care Chiropractic P.C. shall be appointed as my agent to endorse drafts or to sign my name on any checks for payment of my bill for chiropractic services rendered.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Care Chiropractic P.C. to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

PRINT NAME:_____SIGNATURE:_____Date:_____

Notice of Privacy Practices

We are committed to preserving the privacy of your personal information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing how medical information about you may be used and disclosed and how you can access this information.

- We may use or disclose to others your medical information for purposes of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws to use and disclose your medical information for the purposes without your consent or authorization. We may be required to release Immunization Records to schools.
- We are required to notify you and reporting agencies if a breach of your information has occurred.
- We will request to email patient statements; however, due to the risks involved in electronic transmission, you may choose not to participate.
- Your health information is protected for 50 years after your death. Your family may request and be given access to your health information as required by law.
- We will not send you marketing information regarding our products and services. We will not release your information for marketing purposes.
- You have important rights related to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your health information, requesting that we communicate with you confidentially, and complaining if you feel that your rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the top right corner of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of the most current NOTICE in effect. Please ask the front desk if you would like a copy.
- You have the right to restrict the release of your health information by written request. Physicians may not disclose information about care the patient has paid for out of pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law.
- You have the right to request a copy of your electronic medical records in an electronic format. There may be a fee for this service.
- If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact : **Karen Sonnen, ASCT** of our office at 319-377-7331

Health History

What is the reason for your visit?_____

Have you received other treatment for this condition? Y N Physician/Clinic_____

Chiropractic X-rays MRI Medication Physical Therapy Injections Epidurals Surgery

Other_____

How would you rate your current state of health? never worse 0 1 2 3 4 5 6 7 8 9 10 I feel great!

List all prior surgeries:_____

Any prior motor vehicle accidents:_____ injuries? _____

Any prior major falls, injuries or concussion:_____

Any prior fractures:_____

Any recent ER visit or hospitalization?_____

Have you had any x-rays or imaging of the area of concern in the past 5 years? Y N Where?_____

Have you had chiropractic care in the past? Y N Any Preferences/concerns?_____

HEART/BLOOD

Y N	Abnormal Bleeding	Y N	Heart Attack	Y N	High Blood Pressure
Y N	AIDS/HIV	Y N	Heart Disease	Y N	Low Blood Pressure
Y N	Anemia	Y N	Heart Murmur	Y N	Pacemaker
Y N	Blood Clots	Y N	Heart Surgery	Y N	Stroke
Y N	Blood Transfusion	Y N	Hemophilia		

If yes, medications and treatments:_____

RESPIRATORY

Y N	Asthma	Y N	Emphysema	Y N	Sleep Apnea
Y N	COPD	Y N	Seasonal Allergies	Y N	Use of CPAP
Y N	Difficulty Breathing	Y N	Sinus Problems		

If yes, medications and treatments:_____

NEUROLOGICAL

Y N	ADD/ADHD	Y N	Cerebral Palsy	Y N	Psychiatric Illness
Y N	Alzheimer's Disease	Y N	Depression	Y N	Other _____
Y N	Anxiety	Y N	Epilepsy/Seizures		
Y N	Autism	Y N	Neuropathy		

If yes, medications and treatments:_____

DISEASES

Y N	Alcohol Abuse	Y N	Liver Disease	Y N	Cancer, Type_____
Y N	Drug Abuse	Y N	Lupus	Y N	Diabetes
Y N	Hepatitis	Y N	Thyroid Disease		
Y N	Kidney Disease	Y N	Other_____		

If yes, medications and treatments:_____

Medical Conditions

Y N	Acid Reflux/GERD	Y N	Frequent Headaches	Y N	Sjogrens Syndrome
Y N	Arthritis	Y N	Glaucoma	Y N	Skin Conditions
Y N	Artificial Joints	Y N	High Cholesterol	Y N	Special Needs
Y N	Colitis	Y N	Migraine Headaches	Y N	Tuberculosis (TB)
Y N	Fever Blisters/Cold Sores	Y N	Rheumatoid Arthritis (RA)	Y N	Ulcers
Y N	Fibromyalgia	Y N	Shingles	Y N	Other_____

If yes, medications and treatments:_____

Musculoskeletal Issues:

Y N	Bulging or Slipped Disc	Y N	Mid-back Pain	Y N	Sciatica
Y N	Degenerative Disc Disease	Y N	Neck Pain	Y N	Scoliosis
Y N	Joint Pain	Y N	Prior Concussion	Y N	Spondylolisthesis
Y N	Low Back Pain	Y N	Prior Whiplash	Y N	Vertigo

If yes, medications and treatments:_____

Family History

Do your parents, grandparents, or siblings have any of the above medical conditions? Y N

If yes, specify the condition and family member._____

_____

Social History

Y N	Tobacco Use (type)_____ Quit Date _____	Y N	Drug Use (type) _____	Y N	Regular Exercise (type,frequency)_____
Y N	Alcohol Use (drinks/week)_____	Y N	Caffeinated Drinks (units/day)_____	Y N	Sports & Hobbies_____

Women Only

Y N Pregnant Due Date_____

Informed Consent for Chiropractic Care

Nature and Purpose of Chiropractic Procedures: The practice of chiropractic includes many standard examination and testing procedures, including physical examination, orthopedic and neurological testing, palpation, specialized instruments, radiology exams, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession –the chiropractic adjustment. Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s). There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of quick precise movement over a very short distance to a specific segmental contact point of a vertebra. Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors.

AUTHORIZATON FOR CHIROPRACTIC CARE: I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the 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 and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Signature_____ Date_____ Print Responsible Party _____

(Patient or Representative if patient is a minor)