Confidential Patient History

PLEASE PRINT

Name: Last _____ First _____ MI _____

How would you like to be addressed/nickname? _____Home Phone_____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status (Circle One): S M W D Sep No. of Children _____
Race: □ Caucasian □ African American □ Asian □ Native American □ Hispanic Gender: M F

SS# _____ Driver's License # _____

Employer _____ Occupation _____ Years on Job _____

Employer's Address _____ City _____ State _____ Zip _____

Mobile Phone _____ Work Phone _____ E-Mail _____
May we use your e-mail address to contact you? □ Yes □ No Insurance Company _____

Do you have health insurance where you work? □ Yes □ No Plan/Group # _____

Spouse's Name _____ Birth Date _____ SS# _____

Spouse's Employer _____ Occupation _____ Years on Job _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone _____ Mobile Phone _____ E-Mail _____
Does your spouse have health insurance at work? □ Yes □ No
Insurance Company _____ Plan/Group # _____

How did you find out about our office? _____ May we thank them? □ Yes □ No

Have you previously received chiropractic care? □ Yes □ No How long ago? _____

Chiropractor's Name, clinic and location _____
Have any family members ever received chiropractic care? □Yes □No Have you had any additional testing? □Yes □No
□ MRI/date/where _____ □ CT Scan/date/where _____
□ Bone Scan/date/where _____ □ Nerve Conductance/date/where _____
Family Doctor's name, clinic and location _____

Date of last complete physical examination _____
What type of health care are you seeking? □ Relief □ Corrective □ Long Term □ Will discuss with the doctor
Is your condition due to an accident? □ Yes □ No Date of accident _____ □ Auto □ Work Comp □ Other

Attorney's Name _____

Emergency Contact Name _____

Relation to you _____ Phone _____
Please check who is responsible for your bill, **YOU** and: □ No one else □ Spouse □ Parent or Guardian
□ Worker's Comp □ Auto Insurance □ Medicare □ Medical Assistance (Medicaid) □ Health Insurance
The information provided above has been verified and is correct.

Patient Legal Name Print_____ Date of Birth_____

Patient Signature _____ Date _____

Parent or Guardian's Signature _____

Staff Initials _____

Problem Focused History

Describe your health problem that you are here for. Be as specific and as detailed as possible.

_____

_____

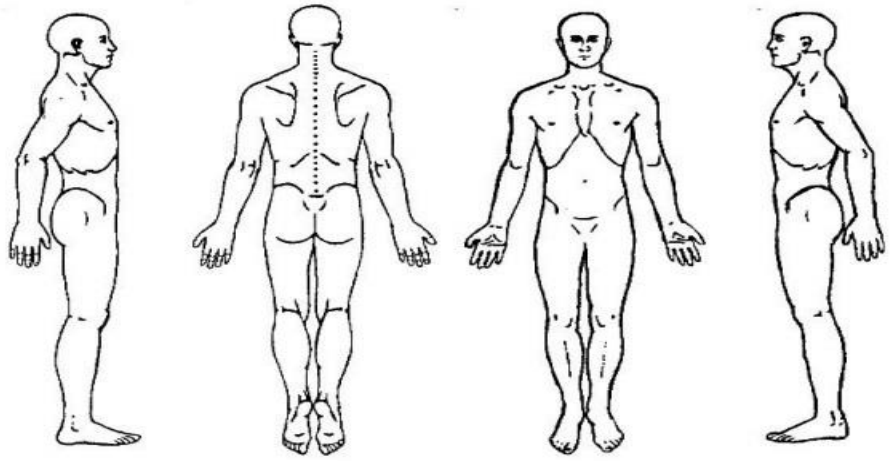
_____

_____

Was this injury caused by: □ Vehicle □ Work □ Home □ Other □ N/A

Mark on the pictures where you have symptoms. Use the letters below to indicate the type of pain.

A=Aching B=Burning C=Cramping D=Dull Throbbing H=Headache
M=Muscle Stiffness N-Numbness S=Sharp/Stabbing T=Tingling



General overall condition: On a scale of 0-10, with 0 meaning NO symptoms/can function normally, and 10 meaning very severe symptoms/cannot function at all, where would you rate yourself overall? (Place an X on the line for average pain).

0 1 2 3 4 5 6 7 8 9 10

No Symptoms Very Severe Symptoms

Have you ever seen a medical doctor, doctor of chiropractic or physical therapist for this problem? □ Yes □ No
Please list the name and type of provider, and date seen. _____

Do you have **ANY** other health problems or symptoms that have not yet been covered today? □ Yes □ No
Please list them. _____

_____

_____

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient Legal Name Print_____ Date of Birth_____
Patient's Signature _____ Date _____
Parent or Guardian's Signature _____Staff Initials _____

Individual Complaint Form

Please describe *<u>each separate</u>* complaint/symptom on separate complaint forms. Be as specific as possible.

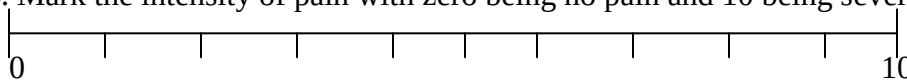
Doctor's Notes

1. Complaint/Symptom and description: _____ 1. _____

2. Date Started: _____ 2. _____
   Explanation: _____
   How did it start? _____
   Who did you tell? _____

3. Describe the pain: _____ 3. _____

4. Mark the intensity of pain with zero being no pain and 10 being severe. 4. _____



(O = now, X = average, B = best, W = worst)

5. Does the pain radiate? Y N Where? _____ 5. _____

6. How often do you experience your symptoms? 6. _____
   A. Constantly (76-100% of the day)
   B. Frequently (51-75% of the day)
   C. Occasionally (26-50% of the day)
   D. Intermittently (0-25% of the day)

7. How do your symptoms affect your activities of daily living? 7. _____
   - □ No complaints
   - □ Mildly forgotten with activity
   - □ Moderate, interferes with activity
   - □ Limiting, prevents full activity
   - □ Intense, preoccupied with seeking relief
   - □ Severe, no activity is possible

8. What activities/positions make it worse? _____ 8. _____

9. What activities/positions make it better? _____ 9. _____

10. Past history of symptoms? _____ 10. _____

Patient Legal Name Print_____ Date of Birth_____

Individual Complaint Form

Please describe *<u>each separate</u>* complaint/symptom on separate complaint forms. Be as specific as possible.

Doctor's Notes

1. Complaint/Symptom and description: _____ 1. _____

2. Date Started: _____ 2. _____
   Explanation: _____
   How did it start? _____
   Who did you tell? _____

3. Describe the pain: _____ 3. _____

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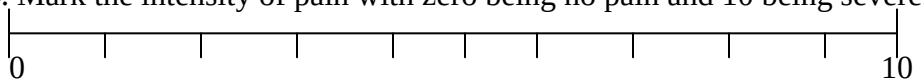

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Patient Legal Name Print_____ Date of Birth_____

Individual Complaint Form

Please describe *<u>each separate</u>* complaint/symptom on separate complaint forms. Be as specific as possible.

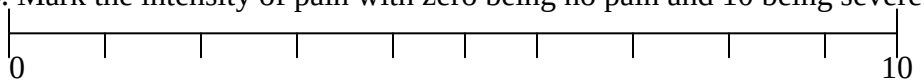
Doctor's Notes

1. Complaint/Symptom and description: _____ 1. _____

2. Date Started: _____ 2. _____
   Explanation: _____
   How did it start? _____
   Who did you tell? _____

3. Describe the pain: _____ 3. _____

4. Mark the intensity of pain with zero being no pain and 10 being severe. 4. _____



(O = now, X = average, B = best, W = worst)

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8. What activities/positions make it worse? _____ 8. _____

9. What activities/positions make it better? _____ 9. _____

10. Past history of symptoms? _____ 10. _____

Patient Legal Name Print_____ Date of Birth_____

ProCare Chiropractic Clinics

YOUR HEALTH AND WELL-BEING QUESTIONNAIRE (RAND 12)

This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question. Some questions may look like others, but each one is different. Check the **ONE** box that best represents your response.

1.) In general, would you say your health is:

- □ 1 Excellent.
- □ 2 Very good.
- □ 3 Good.
- □ 4 Fair.
- □ 5 Poor.

The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2.) <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	□ 1	□ 2	□ 3
3.) Climbing <u>several</u> flights of stairs	□ 1	□ 2	□ 3

During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	Yes	No
4.) <u>Accomplished less</u> than you would like.	□ 1	□ 2
5.) Were limited in the <u>kind</u> of work or other activities.	□ 1	□ 2

During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	Yes	No
6.) <u>Accomplished less</u> than you would like.	□ 1	□ 2
7.) Didn't do work or other activities <u>as carefully as usual</u>.	□ 1	□ 2

8.) During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (including both work outside the home and housework)?

- □ 1 Not at all.
- □ 2 A little bit.
- □ 3 Moderately.
- □ 4 Quite a bit.
- □ 5 Extremely.

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks……

	All	Most	A good bit	Some	A little	None
9.) Have you felt calm and peaceful?	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
10.) Did you have a lot of energy?	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
11.) Have you felt downhearted and blue?	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6

12.) During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?

- □ 1 All of the time.
- □ 2 Most of the time.
- □ 3 Some of the time.
- □ 4 A little of the time.
- □ 5 None of the time.

Patient Legal Name Print_____ Date of Birth_____

ProCare Chiropractic Clinics

LOW BACK PAIN & DISABILITY QUESTIONNAIRE

☐ I am not having any low back pain at this time Patient Initial_____ Staff Initial_____

This questionnaire has been designed to give the doctors information as to how your pain has affected your ability to manage everyday life. Please answer **every section** and mark in each section the **ONE** box which best describes you.

1. PAIN INTENSITY

- ☐ 0 The pain comes and goes and is very mild.
- ☐ 1 The pain is mild and does not vary much.
- ☐ 2 The pain comes and goes and is moderate.
- ☐ 3 The pain is moderate and does not vary much.
- ☐ 4 The pain comes and goes and is severe.
- ☐ 5 The pain is severe and does not vary much.

2. PERSONAL CARE (washing, dressing, etc.)

- ☐ 0 I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ 1 I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ 2 Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ 3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ 4 Because of the pain, I am unable to do some washing and dressing without help.
- ☐ 5 Because of the pain, I am unable to do any washing or dressing without help.

3. LIFTING

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights but it causes extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor.
- ☐ 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ 4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 5 I can only lift very light weights at the most.

4. WALKING

- ☐ 0 Pain does not prevent me from walking any distance.
- ☐ 1 Pain prevents me from walking more than 1 mile.
- ☐ 2 Pain prevents me from walking more than ½ mile.
- ☐ 3 Pain prevents me from walking more than ¼ mile.
- ☐ 4 I can only walk using a cane or crutches.
- ☐ 5 I am in bed most of the time and have to crawl to the toilet.

5. SITTING

- ☐ 0 I can sit in any chair as long as I like without pain.
- ☐ 1 I can only sit in my favorite chair as long as I like.
- ☐ 2 Pain prevents me from sitting for more than 1 hour.
- ☐ 3 Pain prevents me from sitting for more than ½ hour.
- ☐ 4 Pain prevents me from sitting for more than ¼ hour.
- ☐ 5 Pain prevents me from sitting at all.

6. STANDING

- ☐ 0 I can stand as long as I want without pain.
- ☐ 1 I have some pain while standing, but it does not increase with time.
- ☐ 2 I cannot stand for longer than 1 hour without increasing pain.
- ☐ 3 I cannot stand for longer than ½ hour without increasing pain.
- ☐ 4 I cannot stand for longer than 10 minutes without increasing pain.
- ☐ 5 Pain prevents me from standing at all.

7. SLEEPING

- ☐ 0 I get no pain in bed.
- ☐ 1 I get pain in bed, but it does not prevent me from sleeping well.
- ☐ 2 Because of pain, my normal night's sleep is reduced by less than one-quarter.
- ☐ 3 Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ 4 Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ 5 Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- ☐ 0 My social life is normal and gives me no pain.
- ☐ 1 My social life is normal, but increases the degree of pain.
- ☐ 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.).
- ☐ 3 Pain has restricted my social life, I don't go out very often.
- ☐ 4 Pain has restricted my social life to my home.
- ☐ 5 I have hardly any social life because of pain.

9. TRAVELING

- ☐ 0 I get no pain while traveling.
- ☐ 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ 2 I get extra pain while traveling, but it doesn't compel me to seek alternative forms of travel.
- ☐ 3 I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ 4 Pain restricts all forms of travel.
- ☐ 5 Pain prevents all forms of travel except that done lying down.

10. CHANGING DEGREE OF PAIN

- ☐ 0 My pain is rapidly getting better.
- ☐ 1 My pain fluctuates, but overall is definitely getting better.
- ☐ 2 My pain seems to be getting better, but improvement is slow at present.
- ☐ 3 My pain is neither getting better or worse.
- ☐ 4 My pain is gradually worsening.
- ☐ 5 My pain is rapidly worsening.

ProCare Chiropractic Clinics (11/04) Revised (12/04) (03/08)(06/18)

Hudson-Cook N, Tomes-Nicholson K, Breen A. The Revised Oswestry Low Back Pain Questionnaire. Thesis, Anglo-European College of Chiropractic.

Patient Legal Name Print_____ Date of Birth_____

ProCare Chiropractic Clinics

NECK PAIN & DISABILITY QUESTIONNAIRE

☐ I am not having any neck pain at this time Patient Initial_____ Staff Initial_____

This questionnaire has been designed to give the doctors information as to how your pain has affected your ability to manage everyday life. Please answer **every section** and mark in each section the **ONE** box which best describes you.

1. PAIN INTENSITY
- ☐ 0 I have no pain at the moment.
- ☐ 1 My pain is very mild at the moment.
- ☐ 2 My pain is moderate at the moment.
- ☐ 3 My pain is fairly severe at the moment.
- ☐ 4 My pain is very severe at the moment.
- ☐ 5 My pain is the worst imaginable at the moment.

2. PERSONAL CARE (washing, dressing, etc.)
- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself and I am slow and careful.
- ☐ 3 I need some help, but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self care.
- ☐ 5 I do not get dressed, wash with difficulty, and stay in bed.

3. LIFTING
- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives extra pain..
- ☐ 2 Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift very light weights.
- ☐ 5 I cannot lift or carry anything at all.

4. READING
- ☐ 0 I can read as much as I want with no neck pain.
- ☐ 1 I can read as much as I want with only slight neck pain.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want due to moderate neck pain.
- ☐ 4 I can hardly read at all because of severe neck pain.
- ☐ 5 I cannot read at all.

5. HEADACHES
- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches which come infrequently.
- ☐ 2 I have moderate headaches which come infrequently.
- ☐ 3 I have moderate headaches which come frequently.
- ☐ 4 I have severe headaches which come frequently.
- ☐ 5 I have headaches almost all the time.

6. CONCENTRATION
- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with mild difficulty.
- ☐ 2 I have mild difficulty concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I find it very difficult to concentrate when I want to.
- ☐ 5 I cannot concentrate at all.

7. WORK
- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of my usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I cannot do any work at all.

8. DRIVING
- ☐ 0 I can drive without any neck pain.
- ☐ 1 I can drive as long as I want with slight pain in my neck.
- ☐ 2 I can drive as long as I want with moderate pain in my neck.
- ☐ 3 I cannot drive as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I cannot drive my car at all.

9. SLEEPING
- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than 1 hr. sleeplessness).
- ☐ 2 My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ 3 My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ 4 My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hrs. sleepless).

10. RECREATION
- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck.
- ☐ 5 I cannot do any recreation activities at all.

ProCare Chiropractic Clinics (11/04) Revised (12/04) (03/08)(06/18)

Vernon H., Mior S. The Neck Disability Index: A Study of Reliability and Validity. JMPT 1991; 14:409-415.

Patient Legal Name Print_____ Date of Birth_____

ProCare Chiropractic Clinics

ROLAND-MORRIS ***LOW BACK*** PAIN DISABILITY QUESTIONNAIRE

☐ I am not having any low back pain at this time Patient Initial_____ Staff Initial_____

Please read carefully:

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you ***today****.*

- ☐ **I stay at home most of the time because of my back.**
- ☐ **I change position frequently to try and get my back comfortable.**
- ☐ **I walk more slowly than usual because of my back.**
- ☐ **Because of my back, I am not doing any jobs that I usually do around the house.**
- ☐ **Because of my back, I use a handrail to get upstairs.**
- ☐ **Because of my back, I lie down to rest more often.**
- ☐ **Because of my back, I have to hold on to something to get out of an easy chair.**
- ☐ **Because of my back, I try to get other people to do things for me.**
- ☐ **I get dressed more slowly than usual because of my back.**
- ☐ **I stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **My back is painful almost all of the time.**
- ☐ **I find it difficult to turn over in bed because of my back.**
- ☐ **My appetite is not very good because of my back pain.**
- ☐ **I have trouble putting on my socks (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of my back pain, I get dressed with help from someone else.**
- ☐ **I sit down for most of the day because of my back.**
- ☐ **I avoid heavy jobs around the house because of my back.**
- ☐ **Because of back pain, I am more irritable and bad tempered with people than usual.**
- ☐ **Because of my back pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

ProCare Chiropractic Clinics (11/04) Revised (03/08)(06/18)

Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low Back Pain. Spine 1983; 8(2): 141-144.

Patient Legal Name Print_____ Date of Birth_____

ProCare Chiropractic Clinics
HEADACHE DISABILITY INDEX

☐ I am not having any headaches at this time Patient Initial_____ Staff Initial_____

INSTRUCTIONS: Please CIRCLE the correct response:

I have a headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than 1 per week
My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check (√) "YES", "SOMETIMES", OR "NO" to each question. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches.			
F7. Because of my headaches I am less likely to socialize.			
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel a headache starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of my headaches.			
E14. My headaches place stress on my relationship with family and friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

Score Total: _____; E_____; F_____
(100) (52) (48)

ProCare Chiropractic Clinics. (11/04)(06/18)

Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.

Patient Legal Name Print_____ Date of Birth_____

H-1

ProCare Chiropractic Clinics

BUSINESS ARRANGEMENTS

Please check the applicable area:

☐ INSURANCE – As a service to me, it is ProCare's policy to accept assignment of insurance benefits in lieu of cash payments for services rendered and to collect from my insurance company first before looking to me for payment. My annual deductible will be paid where applicable. I will pay my portion (the co-pay) with each visit or weekly and pay any balance denied by my insurance company within ten days of denial.

☐ PRIVATE PAY (WITHOUT INSURANCE) – I have no insurance company or third party liable for my health expenses. I will bring my account current each visit or weekly.

☐ MEDICARE – I understand that chiropractic adjustments to my spine is the only procedure at ProCare that is considered a covered expense by Medicare and that it takes exhaustive effort by ProCare to secure Medicare reimbursement for my adjustments. WPS, my Wisconsin Medicare Carrier, can arbitrarily impose very strict guidelines for their payment of my adjustments, **even though they are medically necessary**. ProCare will make every reasonable attempt to secure payment for my adjustment from WPS. However, **I am financially responsible** for all office visits, examinations, x-rays, other therapies and treatments I receive at ProCare. My signature further indicates that **I accept the responsibility for payment of my care** at ProCare.

I also understand that ProCare does **not** submit to Medicare supplemental insurance carriers because most of them communicate with Medicare directly. I understand that if I am going to submit to a supplemental insurance carrier that I must wait for the Medicare "explanation of benefits" and include a copy with my submission.

☐ STATE MEDICAL ASSISTANCE – I understand that the amount paid by the state is limited in some aspects, and that non-covered items will be my responsibility for payment. Adjustments and most x-rays are covered expenses under most circumstances. I also understand that the amount paid by the state for covered items is considerably less than ProCare's normal fees.

CLINIC POLICIES

1. PAYMENT is due at the time of service, unless other arrangements have been made.
2. An INSURANCE CONTRACT is between the patient and the patient's insurance company; therefore, it is the responsibility of THE PATIENT to keep the amount current.
3. Patients involved in LITIGATION (law suits) are, as others, responsible for their services here at the clinic.
4. Any fees for services rendered will be immediately due and payable for patients suspending or terminating care.
5. It is understood and agreed that any amount paid to ProCare, for X-RAYS, is for evaluation purposes only and the films will remain the permanent property of ProCare Chiropractic Clinics.
6. To be valid, all SPECIAL PROMOTIONS must be presented at the time of the **FIRST** visit to ProCare. Services offered during a special promotion are not charged to your insurance company nor are they reimbursable from your insurance company.

I understand and agree that ProCare Chiropractic Clinics has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical evaluation is not considered treatment.

I UNDERSTAND THAT IF I FAIL TO KEEP MY ACCOUNT CURRENT, AN INTEREST CHARGE OF 1 ½ % PER MONTH WILL BE ADDED TO MY PATIENT BALANCE.

My signature is an acknowledgement that I understand and agree to abide by the policies stated above. My signature also authorizes that payment be made directly to ProCare Chiropractic Clinics for any and all insurance benefits or reimbursement for services rendered by ProCare; as well as authorizes the release of any information concerning my health and health care services to my insurance companies, health plan or Medicare.

Patient Legal Name Print_____ **Date of Birth**_____

Patient's Signature _____ **Date** _____

MINOR ♦ PATIENT WITH LEGAL GUARDIAN

Patient's name, PRINTED _____

I hereby request and authorize the doctors and staff of ProCare Chiropractic Clinics to perform diagnostic tests and render care to the patient named above. This authorization is intended to include radiographic examination at the doctor's discretion. I give ProCare Chiropractic permission to see the patient named above for continued care, even without my presence during a time of service. As of the date below, I have the legal right to select and authorize health care services for the patient named above. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify ProCare Chiropractic Clinics.

Guardian's Signature _____ Date _____

Guardian's name, PRINTED _____

Guardian's relationship to the patient _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. **The following person(s) have my permission to receive my personal health information: _____**

Patient's Signature:_____Date:_____

Guardian'sSignatureAuthorizingCare:_____Date:_____

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

Printed Name_____ Date_____

Patient or Guardian Signature_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices
Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Patient's Name_____ Date_____

Signature of Patient or Parent/Guardian _____