SALINA
CHIROPRACTIC

PAGE 1 - NEW PATIENT CONFIDENTIAL INFORMATION:
Today's Date_____ Name – First_____ MI ____
Last_____ Date of Birth _____ Age _____
SS#_____ Address _____
City _____ State_____ Zip_____ Home Phone _____
Work Phone _____ Cell _____ Email _____
Preferred method of contact: ___ Call ___ Text ___Email
___ Married ___ Single ___ Divorced ___ Widowed Spouse Name _____
Primary Care Physician _____ Most Recent Visit _____
Your Employer _____ Job Description _____
Reason for visit today: _____
Is this related to a: __ work injury __ automobile accident Date of Injury _____
Chief Complaint Today: __ Neck pain __ Lower back pain __ Headaches __
Mid back pain __ Shoulder pain – L R __ Arm pain – L R __ Leg pain – L R __
Feet pain – L R __
Other:_____
Pain Level today: 0=no pain 10=severe pain _____
How long have you had this problem? _____
What caused this problem? _____
Does your pain come and go? Or Is the pain constant? ___ comes and goes ___ constant
What makes it worse? __ sitting __ standing __walking __ bending __lifting __driving
__ house work __yard work __ weather changes __ Other: _____
What makes it better? __sitting __ standing __walking __ bending __ rest __ice __heat
__ medication __ massage __ sleeping __ other: _____
Have you had this problem in the past? __ no __ yes –
When?_____ Does your pain affect your sleep? __no __ yes -
__no sleep __ restless sleep __ poor sleep
How do you feel first thing in the morning getting up? __good __ not bad ___ bad
Are you currently taking medication, including over the counter medication, for your pain? __ No __ Yes – List: _____
Is your problem: ___ staying the same with time ___ getting worse with time __ getting better Any additional information you would like to report about your chief complaint:

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Page 2 – PATIENT NAME_____ Date_____

SECONDARY COMPLAINTS: I also have: __ neck pain __ headaches __ mid back pain __ lower back pain __ shoulder pains __arm symptoms __leg symptoms __feet pain __ other: _____
Any information you would like to report about secondary complaints:_____

Medical History: Have you seen a chiropractor in the past? __ No __Yes
If yes, when was your last chiropractic treatment? _____
What problem were you treated for? _____
Was your experience: ___ good: treatment helped ___not good: treatment did not help
What did you like? _____
What did you not like? _____

Current Medical Problems:
__ High blood pressure __ heart disease __ arthritis __ thyroid problems __ digestive problems __ asthma __ cancer __ AIDS / HIV __ alcoholism __ chemical dependency __osteoporosis __diabetes __emphysema __hepatitis __multiple sclerosis __ prostate problems __tuberculosis __ venereal disease __ polio __epilepsy __kidney disease __ liver disease __ stroke __ psychiatric care __pace maker __metal implants __ depression __ Other:_____

Have you had any major accidents or injuries in the past? __ No __ Yes
If yes, please describe and note date:_____

Have you broken any bones in the past? __ no __ yes
If yes, please describe and note dates:_____

Have you had any surgeries in the past? __ no __ yes
If yes, please list and note dates:_____

SALINA
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PAGE 3 - PATIENT NAME_____ Date_____

Are you taking any prescription medications? __ no __ yes
If yes, please list or attach list:_____

Are you taking any over the counter (OTC) medications? __ no __ yes
If yes, please list or attach list:_____

Do you have any family history of back problems? __no __ yes
If yes, please describe:_____

Social History: __ Smoking - ___ packs per day __ Alcohol - ___ drinks per week __
Coffee / caffeine drinks - ___ cups / drinks per day __ High stress level –
Cause- _____

__ Exercise: __ never __ rarely __occasional __ regularly __ daily
Females: Are you pregnant? __ No __ Yes __

Possibly Additional Information: I am interested in: __ Finding out what's wrong

__ Chiropractic adjustments - __ traditional __ gentle __ Instrument __ Spinal Decompression __ Acupuncture __ Second opinion __ I'm scared __

I have concerns regarding _____

EMERGENCY CONTACT: Name _____ Phone _____
Relationship_____

How were you referred to our office?_____

Patient Signature _____ Date_____

THANK YOU FOR CHOOSING OUR OFFICE!

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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 operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning privacy of your Patient Health Information we encourage you to read the HIPPAA 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, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic 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 to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given 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 right to 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 that 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 healthcare 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.

Name of Patient _____ Signature _____Date_____

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Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his / her hands or a mechanical device in order to manipulate your joints. You may feel a "click" or "pop", such as when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fracture of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications.

Probability of Risks Occurring: The risks of complications due to a chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered "rare".

Other Treatment Options which could be Considered:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- Medical Care, typically anti-inflammatory medications, muscle relaxants, and pain medications. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risks of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay in treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay in treatment will complicate the condition and make further rehabilitation more difficult.

Other risks / unusualRisks: I have had the following risks of my particular case explained to me: I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment.

I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

Patient Signature and Date For Salina Chiropractic and Date

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FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE – For patients without insurance we require payment at the time of service, of if you prefer you may pay for a series of treatments at a time to avoid having to make payments each visit. We accept cash, personal checks, Visa, Master Card, Debit cards, and health savings accounts. Personal checks that do not clear on first presentation will be accessed a $30.00 fee.

GROUP OR INDIVIDUAL INSURANCE AND MANAGED CARE PLANS - When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered service, deductibles, and co-pays. Co-pays are due at the time of service. You may pre-pay co-pays to avoid having to make payments each visit if you prefer. Any unused co-pays will be refunded.

INTEREST AND REBILLING CHARGES: I understand and agree that overdue account balances are subject to interest at the rate of 1.5% per month (18% per annum) or $5.00 monthly rebilling charge, whichever is more, until the account is paid in full.

AUTOMOBILE ACCIDENT RELATED INJURIES – Personal injury protection (PIP) normally covers our services 100%. Kansas is a “no fault” State meaning that YOUR automobile insurance will cover your care regardless of who is at fault. If someone else was at fault, your insurance company will seek reimbursement from the other parties insurance. Please notify your insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six (6) months after your care is completed without interest or finance charges. After six (6) months the account will be charged 1.5% per month of $5.00, whichever is more, until paid in full. Once the claim is settled, or if you suspend or terminate care, any fees for services are due immediately.

FEE FOR NO SHOWS – If you must miss a scheduled appointment, call to reschedule or cancel. Do not “No Show”. We do charge a $40.00 fee for all no shows. This fee is the patient responsibility and is not billable to insurance. When patients “no show” they leave a gap in our schedule that could have been used by someone else wanting care.

I have read, understand, and agree to the above financial policy of Salina Chiropractic.

_____ _____

Patient or responsible party signature Date