Dr. Cheree Sandness-Johnson	Chiropractic Healing Center

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Can we use your email address to contact you concerning your care? Y/N _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

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Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

_____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids	_____ Birth control	_____ Laxatives
_____ Antibiotics	_____ Chemotherapy	_____ Insulin
_____ Anticonvulsants	_____ Cortisone	_____ Recreational drugs
_____ Antidepressants	_____ Diabetic medications	_____ Relaxants/Sleeping pills
_____ Antifungal	_____ Diuretics	_____ Thyroid medication
_____ Aspirin/Ibuprofen	_____ Heart medications	_____ Tylenol/acetaminophen
_____ Asthma inhalers	_____ High blood pressure	_____ Ulcer medications
_____ Beta blockers	_____ Hormone Therapy	OOther: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS / FINANCIAL POLICY

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions, attorney & court filing fees, or interest rates assigned by collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

PATIENT PRINTED NAME: _____

SIGNATURE: _____ Date: _____

Dr. Cheree
Sandness-Johnson

Chiropractic Healing Center

CONSENT TO TREAT

It is important to acknowledge the difference between care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

The doctor will conduct a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT

A patient, incoming to the doctor of chiropractor, gives permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The patient's condition will be discussed in a private room. The chiropractic adjustment and clinical procedures are usually beneficial and seldom cause any problem. *The patient will treat in a community room*. In rare cases, underlying physical defects. Deformities or pathologies may render the patient susceptible to Injury. The doctor of course, will not give a chiropractic adjustment or health care if she is aware that such care may be contraindicated. Again, it is responsibility of the patient to make it know or learn through health care procedures whatever he/she is suffering from. This would otherwise not come to the attention of the doctor. The doctor of chiropractic is licensed in spinal practice and is available to work with other types of providers in health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS OR VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. In turn, conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

I consent to the treatment offered or recommended to me by my health care provider including soft tissue manipulation. I intent this consent to apply to all my present and future with Dr. Cheree Sandness Johnson

Dated: _____ Day of 20___

Print Name:_____ Signature:_____

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
A basis for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer (s) can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing this consent/disclosure
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.
I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Chiropractic Healing Center Unlimited, Inc dba Chiropractic Healing Center to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____