Chiropractic Healing Center

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: _____ DOB: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Chiropractic Healing Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: _____ Date: _____

SEE BACK OF PAGE

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

SEE BACK OF PAGE

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address:

_____

_____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

Patient Name: _____ Date: _____

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:_____

Dr. Cheree Sandness-Johnson

Chiropractic Healing Center

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:** _____

Welcome to Chiropractic Healing Center! We are committed to providing you with the best chiropractic care possible, and look forward to a long and healthy relationship.

We will file your insurance claims automatically for you. It is imperative that you give us correct, updated and accurate insurance information. Your understanding of your specific insurance policy and of our payment policy will be of great benefit to our relationship. We will make every effort to answer any questions you might have. The following statements are areas that are most frequently misunderstood by the patent. Please review and initial.

1. **Not all services are a covered benefit**. Some insurance companies arbitrarily select certain services they will not cover. It is up to you, the patient, to know what these services are. We will do our very best to assist you in this area; however, this ultimately is your responsibility.

_____ Initial

2. **It is your responsibility to know when a referral is needed**, and to obtain the referral before your appointment. If your primary care physician has any questions regarding the necessity, we will gladly answer them.

_____ Initial

3. **Some insurance policies have a higher co-payment due the specialist physician** than to the primary care physician. Please refer to your card or contract for that amount.

_____ Initial

4. **All co-payments, any deductible that has not been met, and services that are not covered by your contract, are due at the time of your visit.** If we do not participate with your insurance company, payment in full is expected at the time of service. We will file with your insurance company as a courtesy to you.

_____ Initial

If you do not have health insurance, financial arrangements must be made in advance with our billing receptionist. We accept cash, check, MasterCard or Visa. There is a $25.00 charge for any returned check. We reserve the right to require subsequent payments on such accounts in cash or by money order. Your signature below is your acknowledgement of this information. This serves as your authorization to release any necessary medical information to your insurance carrier, to process claims for services rendered. This also serves as your authorization of payment of all medical insurance benefits, which are payable under the terms of your insurance policy, to be paid directly to Chiropractic Healing Center, for services rendered.

Signature _____ Date _____

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your physician are listed below:

97140 – Manual Therapy (included with treatment)	$0
G0283 – Electrical Stem (unattended)	$9

The total cost for the service(s) recommended by your physician is:

$9

(Payment due same day of service if you have Medicare / Teachers*UMR* Insurance)

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Signature: _____ Date: _____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*

PLEASE READ CAREFULLY