Maiden Community Chiropractic

Patient Information

Date: ___/___/_____ Patient ID#:_____

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Social Security #_____

Sex: M / F Date of Birth: ___/ ___/ _____ Marital Status: _____

Cell Phone #: (____) _____ Home Phone #: (____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Phone #: (____) _____

How would you like to receive your appointment reminders?

Text / Email / Phone call (please circle all that apply)

Reason for Visit

What is bothering you today/what hurts?

_____

Do you have pain radiating down your arms or legs? Yes or No

If so, please explain: _____

Are you here as a result of an accident? Yes or No Accident Date: ___/ ___/ _____

Have you ever been treated by a chiropractor before? Yes or No

If so, when? _____

Whom may we thank for referring you? _____

Maiden Community Chiropractic

Name: _____ Date: ___/ ____/ _____

Are you currently taking any medications?

Yes or No

If so, please list:

1. _____ _____mg
2. _____ _____mg
3. _____ _____mg
4. _____ _____mg
5. _____ _____mg
6. _____ _____mg
7. _____ _____mg
8. _____ _____mg
9. _____ _____mg
10. _____ _____mg

Do you have any medication allergies/allergies?

Yes or No (None known)

If so, please list:

1. _____
2. _____
3. _____
4. _____
5. _____

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Informed Consent

When an individual seeks chiropractic care and a practitioner of chiropractic accepts that person as a member of their practice, it is vitally important that both parties have the same desired goals in mind. The objective of chiropractic is to remove a type of nerve interference that can occur from time to time in the body known as vertebral subluxation.

Verbal subluxations are misalignment of one or more of the 24 vertebrae in the spinal column. These misalignments can cause an alteration of nerve functions which in turn causes a distortion and malfunction to the transmission of the mental impulse, resulting in lessening of the body's natural ability to express its maximum health potential.

A chiropractic adjustment is a specific force which may be manual or instrumental which helps the body to bring about a correction of the vertebral subluxation. Our method of correction in this office is by administering specific adjustment to the spine for the correction of vertebral subluxations when detected by careful examination and analysis. We also use therapeutic modalities such as ultrasound, mechanical traction and electric muscle stimulation which have been shown to relieve pain and reduce recovery time.

As with any form of healthcare, there is risk involved with seeking chiropractic care. Those risks include but are not limited to muscle strain, disc injury, fracture, other musculoskeletal conditions and stroke the latter of which is classified as rare. Talk with your doctor and inform them of all your current conditions so that your care may be provided with the least amount of risk possible.

By signing below, I have read and fully understand the above description of chiropractic, the serviced that will be provided and the risk that is involved and hereby give consent for care.

Print Name: _____

Signature:_____ Date: _____

Guardian Print Name: _____

Guardian Signature:_____Date:_____

Maiden Community Chiropractic

This notice describes how information about you may be used and disclosed

In the coursed of your care as a patient at Maiden Community Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your information may be disclosed to another provider/hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your records may be disclosed to your health insurance company or employer.

*Your name, address, phone number and/or email address may be used to contact you regarding appointment reminders or for billing purposes.

*If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voice mail.

*You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

*Therapy may be rendered in rooms where other patients are also being treated.

*Should you need to speak with your doctor at any time in private, the doctor will provide a room for these conversations.

Under federal law, we are also permitted or required to use or disclose your health information without your consent of authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined about, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care. We may also mail information to you regarding your health care or about the status of your account.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created of for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your record should be provided in writing.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our front desk.

This notice is effective as of the date signed below. This notice, and alternations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have agreed to the terms of this notice.

Print Name:_____ Signature:_____ Date:_____

Guardian (if applicable)
Print Name:_____ Signature:_____ Date:_____

NO CALL/NO SHOW CANCELLATION POLICY

We regret patients must sometimes wait a lengthy time to be seen. Due to high demand of appointments and in order to be respectful of the needs of **all** our patients please be courteous and call our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require **24**-hour notice.

There will be a $20.00 charge for every appointment missed without proper notification.

Print Name: _____ Date: _____

Signature: _____