STRIVE CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Name _____ Sex _____Marital Status_____ DOB_____Age_____
Nickname or name you prefer _____ SSN _____
Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Would you like appointment reminders? Email □ Yes □ No Text Message □ Yes □ No
If yes, phone carrier: _____
Employer _____ Occupation _____
Spouse (if applicable)_____ Spouse's Employer _____
Emergency Contact _____ Relationship _____Phone _____

Do you have insurance? (circle) Yes No If yes, please provide front desk with copy of insurance card(s)
Who referred you to, or how did you hear about, our office?_____
Were you referred to a certain doctor in this office?_____
Is your visit due to an accident? (circle) Yes No (If yes, please see front desk for an injury report)
Your present complaints/symptoms _____
List other doctor(s) seen for this condition _____

Personal Medical history (please circle any of the following are relevant to your medical history)

Cancer	Muscular	Rheumatic Fever	Digestive Disorders	Diabetes
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Hepatitis
Tuberculosis	Convulsions	Nervousness	Backaches	Rubella
High Blood Pressure	Epilepsy	Asthma	Numbness	Venereal Disease
Heart Trouble	Concussion	Dizziness	Arthritis	

Have you ever had chiropractic care? (circle) Yes No Date of last adjustment _____
Describe any operations you've had and the dates: _____
Have you been treated by a physician for any health conditions in the last year? Yes No
Describe condition _____
Date of last physical exam _____
Are you now taking any medication? (circle) Yes No What Kind? _____
_____
What supplements/vitamins are you currently taking? _____
Are you pregnant? (circle) Yes No Date of last menstrual period _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse coissued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Strive Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Strive Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's Signature _____ Date _____
Printed name if signed on behalf of patient _____ Relationship _____

OFFICE POLICY

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage

Complimentary Consultation: Strive Chiropractic will conduct a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy: We feel the patient's health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services: Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker's Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance: Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Strive Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Strive Chiropractic will be credited to your account upon receipt.

Appointments: To better serve our patients, we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Our office has a $25.00 no show/late cancellation charge if we fail to receive 24 hours' notice for chiropractic care, and a $25.00-$70.00 no show fee for massage therapy. Please call our office as soon as possible if you are not going to make your scheduled appointment.

Identification Policy: Strive Chiropractic requires a copy of photo identification (ex: driver's license, passport, student ID) be on file in order to receive care. Also, we require an electronic photo be taken and placed into your medical chart for verification purposes.

Questions and Answers: Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Strive Chiropractic clinic policies and agree to honor them:

Patient's Signature _____ **Date** _____

Printed name if signed on behalf of patient _____ **Relationship** _____

PRIVACY PRACTICES AND RELEASES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Strive Chiropractic.

By my signature below I acknowledge the Privacy Practices and Releases.

_____

Patient's signature Date Time

_____

Printed name if signed on behalf of patient Relationship

Additional Disclosure Authority
In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Please list anyone who may need access to your file (ex. spouse, child, parent).

Name: Relationship:

_____

_____

Authorization To Treat A Minor:

As a parent or legal guardian, I hereby authorize treatment of the following Individual for any chiropractic treatment deemed advisable. I also give permission to perform chiropractic treatment if a parent or legal guardian is not available when the child is brought in for treatment.

Patient's Full Name _____ Date of Birth _____

This authorization will be effective as of (Date) _____

Parent or Legal Guardian:_____

Signature _____ Print Name _____

Witnessed by_____ Print Name _____

INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date: _____

NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the service provided to you for the following reasons:

That the particular service is not reasonable and necessary under my insurance companies standards.

For this reason, please read and sign the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services."

_____

Patient's Signature Date

_____

Printed name if signed on behalf of patient Relationship

ASSUMPTION OF FINANCIAL RESPONSIBILITY
Explanation of benefits disclaimer

I, the undersigned patient, completely understand that Strive Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Strive Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Strive Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Strive Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file" to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic.

I understand that Strive Chiropractic may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any copay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

_____

Patient Signature's Date

_____

Printed name if signed on behalf of patient Relationship