Naturally Chiropractic Family Wellness Center

Today's Date:_____

Name:_____ F M Age:___ Birthdate:_____ SS #:_____

Mailing Address:_____ City:_____ Zip:_____

Phone #:_____ Cell#_____ E-mail_____

Marital Status: M S D W Spouse/Guardian's Name:_____ Birthdate:_____ SS #:_____

Number of Children:_____ Ages of Children:_____

Your/Guardian's Occupation & Employer:_____

Work Phone #:_____ Is it OK to Call at Work? Y N

Spouse's Occupation & Employer:_____

What brings you to our office today?_____

Were you injured at work or in an automobile accident? Y N If yes, please give date of injury:_____

How did you hear about our office?_____

CONSENT TO TREAT A MINOR CHILD: (If applicable)

I, the undersigned, the parent or legal guardian of the above named child, hereby authorize the doctor(s) of Naturally Chiropractic Family Wellness Center, or whomever they delegate, to examine, and/or treat the above mentioned child, within the scope of Chiropractic examination and treatment guidelines. I have had any questions or concerns addressed to my satisfaction.

_____ _____ _____

Signature Printed Name Date

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WHY THIS FORM IS IMPORTANT:

As a full spectrum Chiropractic office, we focus on your ability to be healthy & active. Our goals are, first to address the issues that brought you here & second, to offer you the opportunity of improved health potential & wellness services for you & your family in the future. We face chemical, physical & emotional stresses on a daily basis . Most times, effects are gradual & are not even felt until they become serious. Please answer the following questions as completely as possible allowing us to better sees the challenges to your health potential.

- List any complications during or after **your own** birth. (Include forceps, Caesarian, vacuum extraction or induction)

_____

- List any significant childhood illnesses/surgeries, physical or emotional trauma or prolonged medication used.

_____

- Check any of the following health challengers you have faced in the past 5 years (CIRCLE CURRENT ISSUES):

__Headaches	__Numbness/Tingling in limb(s)	__Sleeping problems	__Digestive/Bowel Issues
__Depression	__High Stress (personal/job)	__Emotional Trauma	__Beck/Neck Pain
__Physical Trauma	__Kidney/Bladder/Prostrate Issues	__Menstrual/Hormonal Issues	__Pain in Limb(s)
__Surgery	__Dizziness/Passing out	__Poor Diet/Exercise	__Severe Health Problems

_____

_____

_____

- List any medications you are currently taking (prescription and over the counter) & what they are for:

_____

- **Females only:** Are you, or could you be pregnant? Y N
- Have you been under Chiropractic care before? Y N If so, when and by whom were you last adjusted?_____
- **What result applies best to the level of care you are hoping to obtain from our office?**

___RELIEF -Relief from pain & symptoms to be more comfortable

___CORRECTION -Going beyond relief from pain & correcting the problem at its source

___WELLNESS -To become healthier, focusing on vitality & wellness

I herby certify that the information given on this form is true to the best of my knowledge. I agree to allow this office and its designated staff to perform an assessment and/or treatment on me. I understand that, regardless of any expected insurance contribution or settlement, I am ultimately responsible for any charges I incur at this office.

Signature_____Printed Name_____Date_____

Office Fee Schedule and Financial Policy

Service	Fee
Chiropractic Adjustment	$40**
Mechanical Distraction	$20
Manual Therapy	$30
Assessment/Computerized Spinal Scans	$50 to $150 each
X-Rays (3 view cerv, 2 view thor, 2 view lumbar)	$155

****There is a cash discount adjustment fee of $35 if you do not have insurance benefits or choose not to have us file your insurance claims. Our costs are significantly reduced if we do not file your insurance claims and we pass the discount on to you.**

Financial Policy and Adjustment Packages

- We are committed to providing you & your family with exceptional Chiropractic care & service in a healing environment & have established our financial policies to achieve that goal. In the event you do not have insurance that contributes to Chiropractic care, or if your benefits have been exhausted, we have Adjustment Packages available for purchase for everyone interested in getting the most out of Chiropractic and moving toward full expression of life. These packages are designed to help you & your family take strides in growing stronger and more amazing each day with Chiropractic care. Your options will be discussed in your Chiropractic report.

- If you have insurance that will contribute to your Chiropractic care, we will file your insurance claims for you, as a courtesy, however, keep in mind that **your agreement is between you and your insurance** company & payment for any portion of your financial responsibility is expected in a timely manner. Verification of insurance coverage is NOT a guarantee of payment. We do not base your care recommendations on your insurance coverage & neither should you. It is not uncommon for your insurance coverage to stop in the middle of a care plan. **You are also responsible for keeping track of your visits (how many are covered) for insurance purposes, and when your coverage stops.** For this reason, we have Adjustment Package options to fit various needs, because your health is important to us! It is also important for your family to enjoy the many benefits of Chiropractic-just ask about our Adjustment Packages to make this possible for your family. The investment you make in yourself and your family will pay lifelong dividends.

- **Payment will be expected at the time services are rendered, unless you have arranged an Adjustment Package in advance. If you are paying on a per visit basis, it is an office policy to allow a patient balance of no more than $60 to accrue on an account. We may be able to make flexible payment arrangements with you in advance, but open communication is a must – keep us in the loop and we are happy to discuss it.**

- If you acquire insurance for a special situation, such as Personal Injury, Auto Accident or Worker's Compensation Claim, and choose to utilize that coverage, we will file your insurance claims for you. Personal Injury or Auto Accident claims without PIP coverage will only be accepted on a lien basis if there is Attorney representation. This ensures that you receive the care you need to recover from your injuries and are not left financially responsible for services rendered during care at our office.

I have read, I understand, and I accept the above policies.

Patient Signature Printed Name Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

GOALS & GAINS

PLEASE ANSWER ONLY QUESTIONS 1- 3, SIGN AND DATE. THANK YOU!

1. What are your present health challenges?

____

____

2. What is your progress goal for the next 4-6 weeks, within your reasonable abilities? (**Be specific**.)

____

____

3. What's **ONE** thing you're not doing now, that you **could** do to move you closer to your goal?

____

____

Signature | Printed Name | Date

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FOLLOW-UP ASSESSMENT – TO BE ANSWERED AT YOUR 1ST DYNAMIC ASSESSMENT

1. How would you rate the changes you've experienced since your last assessment? (Circle **one**.)

   Worse☹ No Change 😐 Improved ☺ Awesome! ☺☺

2. Why do you feel this way?

____

____

3. What are some lifestyle changes you've made in the past 4-6 weeks? (Check **all** that apply.)

CHEMICAL:
___Better Quality Foods
___Drinking More Water
___Reducing Caffeine/Nicotine

PHYSICAL:
___Increased Exercise
___More "Movement Breaks"
___More Deep Breathing

EMOTIONAL:
___Increased Quiet Time
___New Hobbies
___More + Self Talk

4. Are there any significant challenges (physical or emotional) that may be hindering your healing process? If so, is there anything we could do to help you? (Resources, information, support, etc.)

____

____

____

Signature | Printed Name | Date
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Naturally Chiropractic Family Wellness Center, Inc. PS – Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Naturally Chiropractic Family Wellness Center, Inc., PS is required by a federal law called the Health Information Portability and Accountability Act, (HIPAA) *of 1996, to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and* privacy practices with respect to your protected health information. Protected health information means any information that is identifiable to you as your personal information, including information on you health care, condition (past, present and future), and treatment, your name, age, address, phone number and social security number.

This notice takes effect April 14, 2003, and will remain in effect until we replace it.

Use and Disclosures of Protected Health Information:

We use and disclose protected health information about you for your treatment, payment for your care, and our business operations. This information may be used by your doctor(s), our office staff, and others outside our office who are involved in your care, payment of these services, operations of your doctor's practice, and any other use required by law. The following are some examples of how we may use or disclose information about you:

- **Treatment**
  We may use and disclose your protected health information to provide, coordinate or manage your health care, and any related services. For example, your protected health information may be disclosed to a physician to whom you have been referred so that the physician may have the necessary information to diagnose and treat you.
- **Payment**
  Your protected health information may be used to obtain payment for your health care services. For example, your protected health information may be disclosed to your health benefits provider to obtain the approval and information necessary to receive payment for your services from that benefits provider.
- **Operations**
  Your protected health information may be disclosed or used to support the business activities of Naturally Chiropractic Family Wellness Center, Inc., Ps. These activities include, but are not limited to, employee review activities, staff training, licensing of the facility and staff, and conducting or arranging for other business activities. For example, we may use your protected health information to contact you regarding an appointment, we may call you by name in the reception room, we may use a sign-in sheet at the front desk where you will be asked to indicate your name.

Other Uses and Disclosures of Protected Health Information:

- **Marketing**
  We may use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products or services that may be of interest to you. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.

- **Incidental Disclosures**
  It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is **NOT** the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

  We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

  The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

We May Be Required By Law to Provide Your Information For Legal and/or Governmental Purposes:

- **If required by law by state or federal agencies, including workers' compensation laws & authorities**
- **Public Health & Safety - to prevent a serious threat to your health & safety, that of the public, or to prevent or control disease**
- **Abuse or Neglect – either child abuse and/or neglect, and/or domestic violence**
- **Oversight agencies – such as those conducting audits, examinations, investigations or licensures**
- **Legal Proceedings – by order of a court or administrative agency, in response to a subpoena, discovery request or other lawful purposes**
- **Law Enforcement – in limited circumstances, i.e. : to identify a witness or missing person**
- **Deceased Person Information – to coroners, medical examiners, and funeral directors to carry out their duties**
- **Specialzed Government Functions – national security and intelligence activities authorized by law, and as required by military authorities if you are a member of the armed services**

We DO NOT and WILL NOT sell your non-public information to anyone. Any other uses or disclosures of your protected health information will only be made with your consent, authorization or opportunity to object, unless required by law.

PLEASE TURN THE PAGE OVER TO COMPLETE YOUR REVIEW OFTHIS INFORMATION AND TO ACKNOWLEDGE YOUR RECEIPT OF THIS INFORMATION.

Your Rights:

The following is a statement of your rights with respect to your protected health information:

- **Your have the right to inspect and copy your protected health information.**
  However, you may note inspect or copy the following records: treatment notes, information compiled in reasonable anticipation or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Your request for inspection and copy must be in writing. Record copying will be accepted at legal copying fees.

- **You have a right to request the restriction of your protected health information.**
  You may ask us not to use or disclose your protected information for the purposes of treatment, payment or operations, or that your information not be disclosed to any of your friends or family members for notification purposes. Your request must be in writing and state the specific restriction and to whom it should be applied.

  Your doctor is not required to agree with your restriction request, if the doctor feels it is in your best interest to use or disclose your information. You then have the right to choose another health care professional.

- **You have the right to request to receive confidential communication from us via an alternative means or location.**
- **You have the right to receive a paper copy of this notice from us, upon request.**
- **You may have the right to have your doctor amend your protected health information.**
  If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of the rebuttal.

- **You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you of any changes by mail. You then have the right to object or withdraw, as provided in this notice.

You may complain to us or to the Department of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not take any retaliatory action should you file a complaint against us.

Security Measures:
We restrict access to non-public information, with federally compliant physical, electronic, and procedural safeguards, to those who need to know that information at levels necessary to conduct our business.

By law, we cannot share your protected health information about care or condition with anyone, including your spouse, without written consent from you. However, we assume that we have permission to leave messages on your answering machine or voicemail, unless you request, in writing, that we do not.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our privacy office in person or by phone.

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices.

Printed Name:_____ Signature:_____ Date:_____