# NEW PATIENT REGISTRATION: CHIROPRACTIC

**PATIENT FULL NAME:** _____

**DOB:** _____ **TODAY'S DATE:** _____ **GENDER:** M F X

**Address**_____

**City**_____ **State** _____ **Zip** _____

**Phone:** _____ ☐ Cell ☐ Home ☐ Work **Message OK?** ☐ Y ☐ N

**Other Phone:** _____ ☐ Cell ☐ Home ☐ Work **Email:** _____

☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Retired

**Do you have kids?** ☐ Y ☐ N **How many?** _____ **How did you hear about us?** _____

**Employer:** _____ **Occupation**: _____ **Phone:** _____

**Emergency Contact**: _____ **Relationship:** _____ **Phone:** _____

**Is this visit due to a motor vehicle accident?** ☐ Y ☐ N **Is this visit due to an on-the-job injury?** ☐ Y ☐ N

**Have you ever seen a chiropractor before?** ☐ Y ☐ N **Have you ever had acupuncture before?** ☐ Y ☐ N

**Primary Care Provider:** _____ **Have you ever had massage before?** ☐ Y ☐ N

## INSURANCE INFORMATION

**Primary Insurance Company:** _____ **Policy Holder:** ☐ Self ☐ Spouse ☐ Parent

**ID#:** _____ **Group#:** _____

**Policy Holder DOB:** _____ **Policy Holder Employer:** _____

**Secondary Insurance Company:** _____**Policy Holder:** ☐ Self ☐ Spouse ☐ Parent

**ID#:** _____ **Group#:** _____

**Policy Holder DOB:** _____ **Policy Holder Employer:** _____

## RESPONSIBLE PARTY INFORMATION: Please fill out if patient is a minor.

**Name:** _____ **Relationship:** ☐ Parent/Legal Guardian ☐ Legal Representative

**Address** (if different): _____ **City**: _____ **State**: _____ **Zip**: _____

**Phone**: _____ ☐ Cell ☐ Home ☐ Work **Date of Birth**: _____

# NW FAMILY WELLNESS CENTER NEW PATIENT REGISTRATION

**PATIENT NAME:** _____ **DOB:** _____

**DATE:** _____

## MEDICAL & SURGICAL HISTORY

**What was the date of your last physical exam?** _____

**How would you describe your health?** _____

**Please list any previously diagnosed medical problems:** _____

_____

_____

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?**
Check **C if Current Condition** or **P if Past Condition** or **F Family Members**

| | | |
|---|---|---|
| ☐C ☐P ☐F Heart Disease | ☐C ☐P ☐F Breast Cancer | ☐C ☐P ☐F Arthritis |
| ☐C ☐P ☐F High Blood Pressure | ☐C ☐P ☐F Other Cancer | ☐C ☐P ☐F Cataracts |
| ☐C ☐P ☐F Hepatitis/Liver Disease | ☐C ☐P ☐F Broken Bones | ☐C ☐P ☐F Glaucoma |
| ☐C ☐P ☐F Positive TB Skin Test | ☐C ☐P ☐F Tuberculosis | ☐C ☐P ☐F Seizures |
| ☐C ☐P ☐F High Cholesterol | ☐C ☐P ☐F Depression / Anxiety | ☐C ☐P ☐F Anemia |
| ☐C ☐P ☐F Thyroid Disorder | ☐C ☐P ☐F Auto-Immune Condition | ☐C ☐P ☐F Headaches / Migraines |
| ☐C ☐P ☐F Artificial Joints | ☐C ☐P ☐F Alcoholism | ☐C ☐P ☐F Pacemaker |

**PLEASE ANSWER THE FOLLOWING QUESTIONS:** Check **Y for Yes** or **N for No**

Monthly Self Breast Exam? ☐Y ☐N  Breast Lumps ☐Y ☐N  Nipple Discharge ☐Y ☐N

**Please list any past surgeries along with the dates of each**: _____

_____

**Please list all prescription medications that you are taking:** _____

_____

**Please list all non-prescription medications, vitamins or herbs that you are taking:** _____

_____

**WOMEN ONLY:**

☐Y ☐N Taking birth control or estrogen? ☐Y ☐N Have you ever? If yes, when did you stop? _____

☐Y ☐N Abnormal vaginal or menstrual bleeding? Pregnant ☐Y ☐N Weeks: _____

# NW Family Wellness Center New Patient Registration

**Patient Name:** _____ **DOB:** _____

**Date:** _____

## HEALTH HABITS

**Do you eat a special diet?** ☐ Y ☐ N **If yes, please describe**: _____

_____

**Do you exercise regularly?** ☐ Y ☐ N **If yes, how many times per week?** _____

**What method of exercise do you use?** _____

**Please answer the following questions:** Check **Y for Yes** or **N for No**

☐ Y ☐ N **Do you smoke?** If yes: What & how much?_____ ☐ Y ☐ N Have you ever smoked?

☐ Y ☐ N **Do you chew tobacco?** If yes: What & how much?_____

☐ Y ☐ N **Do you drink alcohol?** If yes: How many drinks weekly?_____ Monthly? _____

## CURRENT COMPLAINT(S)

**Please describe your current complaint(s) and what are you concerned about today:** _____

_____

**Date your current symptoms started:** _____ **Is the pain?** ☐ Better ☐ Worse ☐ Same as the Onset

**Have you ever had this condition in the past?** ☐ Y ☐ N **If yes, please explain:** _____

_____

**Have you seen any other healthcare practitioners seen for this condition?** ☐ Y ☐ N

**If yes, please list:** _____

**Have you had any recent x-rays/images taken?** ☐ Y ☐ N **When?** _____ **Where?** _____

**Are your symptoms worse during certain times of the day?** ☐ Y ☐ N **If yes, when?**_____

**What have you tried at home to help alleviate your symptoms?** _____

**What makes your symptoms better?** _____

**What makes your symptoms worse?** _____

**Do your symptoms interfere affect your sleep?** ☐ Y ☐ N **Do your symptoms wake you up at night?** ☐ Y ☐ N

**How do you sleep?** ☐ Back ☐ Stomach ☐ Side **Other:** _____

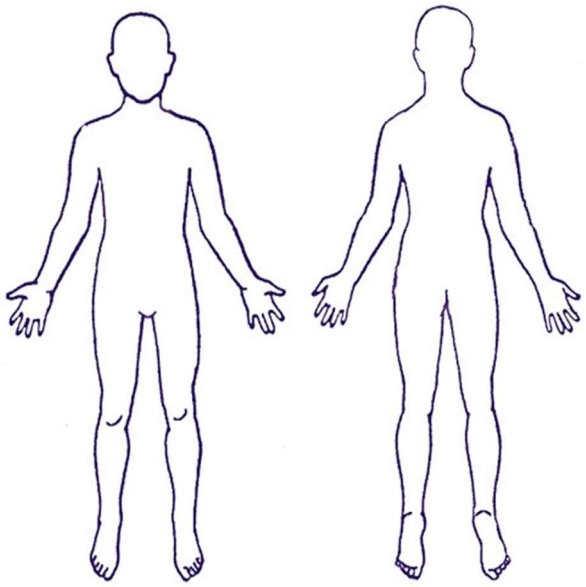
**Do you sleep with a comfortable pillow?** ☐ Y ☐ N **Do you sleep in a comfortable bed?** ☐ Y ☐ N

**Do you wear:** ☐ Heel lifts ☐ Sole lifts ☐ Orthotics Arch supports ☐ Negative Heels ☐ Platform Shoes ☐ Braces

# NW Family Wellness Center New Patient Registration

**Patient Name:** _____ **DOB:** _____

**Date:** _____



## Tell us where you hurt:

Mark the areas on your body where you feel pain on the diagram to the right.

*If your pain radiates, draw an arrow from where it starts to where it stops.

**Use the symbols listed below**

| | |
|---|---|
| **>>>>** | Ache |
| **XXXX** | Burning |
| **====** | Numbness |
| **////** | Stabbing |
| **0000** | Pins/Needles |
| **~~~~** | Throbbing |

**How often are your symptoms present?** (Please check the appropriate box)

☐ 0 – 25% ◆ ☐ 26 – 50% ◆ ☐ 51 – 75% ◆ ☐ 76 – 100%

**In the past week, how much has your pain interfered with your daily activities?**

0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

No Interference — Unable To Carry Out Activities

## SYMPTOM RATING SCALE

Please circle the number(s) in each box that best describes your symptoms.

**0= No Symptoms**

**10 = Unbearable**

What is your symptom intensity **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

What is your symptom intensity **AT ITS WORST**?

0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** symptom intensity?

0 1 2 3 4 5 6 7 8 9 10

# NW Family Wellness Center New Patient Registration

**Patient Name:** _____ **DOB:** _____

## CHIROPRACTIC INFORMED CONSENT

**THE NATURE OF THE CHIROPRACTIC ADJUSTMENT**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click". You may feel a sense of movement.

**ANALYSIS ▪ EXAMINATION ▪ TREATMENT**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Basic Neurological Testing
- Electrical Stim
- Hot/Cold Therapy
- Mechanical Traction
- Orthopedic Testing
- Palpation
- Postural Analysis
- Range of Motion Testing
- Spinal Manipulative Therapy
- Ultrasound
- Vital Signs

**THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT**

Chiropractic adjustments and therapeutic procedures are considered safe and effective methods of care. However, any procedure may have complications. The most common side effects include soreness, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. While rare some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS**

If you chose to use one of the "other treatment" options, you should be aware that there are risks and benefits you may wish to discuss these with your primary medical physician. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

**THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this may complicate treatment making it more difficult and less effective.

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**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with **Mary Coleman, DC** and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Signature: _____ Date: _____

**RELATIONSHIP TO PATIENT**: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative

Office Staff Signature: _____ Date: _____

# NW FAMILY WELLNESS CENTER NEW PATIENT REGISTRATION

**PATIENT NAME:** _____ **DOB:** _____

## CLINIC ACCOUNT POLICY

- Payment is expected as the time of service for services rendered at NW Family Wellness.
- We will bill your insurance company when possible. We request that you pay your Co-Pay, Coinsurance, Deductible or non-covered service fee(s) at the time of service.
- If your insurance policy requires a referral for chiropractic care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.
- We make every effort to get accurate information from your insurance company to estimate costs. Additional charges may be incurred after the claim is processed by your insurance company.
- Information received from your insurance company **IS NOT A GUARANTEE OF BENEFITS**. You are responsible for all charges incurred in this office.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.
- Personal injury accounts (automobile accidents) require the injured party to complete paperwork with their insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you will be required to pay at time of service for your care, you are then solely responsible for any reimbursements through your insurance company.
- Patients paying at the time of service will receive our discounted Time of Service pricing. If you choose to pay at Time of Service, **WE DO NOT BILL FOR THESE SERVICES**. If, at a later date, you ask that we bill your insurance, the discount will be reversed prior to the submission of any billing.
- Our fee schedule is available by request.
- We require 24-hour notice if you need to cancel your appointment. Effective August 1, 2017, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show".
- When two or more "No-Shows" occur a $50 fee will be charged, fee due before rescheduling.

**I have read and understand the above account policy.**

Signature: _____ Date: _____

**RELATIONSHIP TO PATIENT**: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative

_____ _____

Office Staff Signature Date

## NW Family Wellness Center New Patient Registration

**Patient Name:** _____ **DOB:** _____

# ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan ad direct my treatment and follow-up among the health care providers who may be directly or indirectly involved in providing my treatment.
- Obtain payment from 3rd party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____
Print Name

_____
Signature

_____
Date

## For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining Acknowledgement
- ☐ Other (Please Specify) _____

_____ _____
Staff Signature Date

# NW Family Wellness Center No-Show Policy

Thank you for trusting your medical care to NW Family Wellness. Quality care for our patients is our priority. When you schedule an appointment with our clinic we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, ***we require no less than 24 hours prior to your scheduled appointment***. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

## Appointment Cancellation/No Show Policy

- Effective August 1, 2017, any established patient who ***fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show"***.
- When two or more "No-Shows" occur a $50 fee will be charged, fee due before rescheduling.
- We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.
- Any new patient who fails to show for their initial visit will NOT be rescheduled.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

## Definition of a "No-Show" Appointment

NW Family Wellness defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

### How to Avoid Getting a "No-Show"

- Confirm your appointment
- Arrive 5-10 minutes early
- Give 24 hours' notice to cancel appointment

I have read and understand the Appointment Cancellation/No Show Policy and I agree to its terms.

### Consequences of "No-Show" Appointments

***<u>If you miss 3 or more appointments</u> within a year you may be dismissed from the clinic.***

- Patient dismissal is at the discretion of your provider.
- If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
- Only emergency treatment will be offered within the first 30 days of dismissal.

Signature: _____ Date: _____

**RELATIONSHIP TO PATIENT**: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative

Office Staff Signature: _____ Date: _____