

Welcome To Our Office



Mission Statement

Our office is dedicated to educating and adjusting as many families as possible towards optimal health through natural chiropractic care. We believe the greatest care any patient can receive comes from the combination of compassion, empowerment and experience combined with the latest in technology.

CONFIDENTIAL PATIENT INFORMATION

You deserve to be healthy. Life is a miracle and so are you. We are all given the blue-prints, intelligence, tools and systems to live an active, healthy life. Unfortunately, accidents and other challenges can cause a disruption to your health. Through consultation, examination and natural chiropractic care, we will work together so that you can live the quality of life you deserve. Your answers help us determine if chiropractic care can help you. If we do not believe chiropractic care can help your condition, we will advise you and may recommend alternative treatment. *THANK YOU.*

Name: _____ Social Security # _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Telephone: _____ Age ____ Birthdate: _____ Marital Status: M S W D
 Work Telephone: _____ Spouse's Name: _____
 Occupation: _____ Spouse's Occupation: _____
 Employer: _____ Referred by: _____

Health Information

What health goals would like to accomplish through chiropractic care?

- Symptomatic relief / Feel better quickly
- Have a Healthier Spine
- Have a Healthier Body by treating my Nerve System
- Preventative / Wellness Care

Main Complaint _____

How long have you had this condition? _____

Have you had previous Chiropractic Care? Yes No

Does this condition effect your work? Yes No

Does this condition effect your family or social life? Yes No

What aggravates your condition? _____

What helps your condition? _____

Other doctors seen for this condition? _____

What medications are you taking? _____

Any home remedies? _____

Have you had any surgery? Yes No Please describe? _____

Any side effects from drugs/surgery? _____

Date of last physical examination? _____

Are you Pregnant? Yes No

Is there a family history of:

Heart Disease Arthritis Cancer Diabetes Other _____

Father's side:

Mother's side:

Any children? _____

Do you Suffer From:

*(check all that apply
within the past 6 months)*

	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

Complete this section only for Accident Information:

Date: _____ Time: _____ AM / PM Location: _____

How did accident occur? Auto Collision Other

If auto accident Driver Passenger Pedestrian

If auto collision were you struck from Behind Right Side Left Side Front Auto was Parked

Did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No

List the extent of the injuries, as you know them

Did you require post-accident hospitalization? Yes No

Check the symptoms you have noticed since the accident:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? Yes No Dates: _____

Insurance Companies Involved:

My Company: _____

Company of persons responsible for injuries _____

Has an insurance adjuster or company representative regarding this claim contacted you? Yes No

Do you have an attorney that has advised you in this case? Yes No

Name: _____

Address _____

Telephone: _____

Financial Information

How will you pay for your care?

- Cash* – I will pay each visit in full when services are rendered.
- Insurance* – I have coverage, please check and see what benefits I have available for chiropractic care. I understand that until this is verified, that I need to pay all charges in full.
- HMO / PPO that your office participates in* - (Note you will only be responsible for the co-payment on each visit, however if we are not able to verify your coverage, or coverage is different than expected, you are responsible for charges incurred.)
- Payment Plan* - (Our office will review your case and give our best recommendation for care, and will provide you with a payment plan.)

Financial Information (con't)

Please review each item below and check the box when completed.

- All fees are to be paid in full unless other arrangements are made prior to receiving care. We will gladly prepare any reasonable documentation for you to submit to your insurance company for the purpose of reimbursement. Any unreasonable; detailed reports, requests for narratives or additional forms that your insurance company requests will be charged appropriately.
- Medical Necessity:** From time to time a third party payor (insurance company) may review and occasionally reject claims. The rejection does not release you from your responsibility for the services rendered.
- The fee for checks that are returned unpaid will be \$25.00 per incident / check.
- In the rare event that your account is turned over to our collections company, the following fees will apply; all collections fees (33%-50%), legal fees (court costs, filing fees, etc). All balances that are outstanding will be subject to an 18% APR (1.5% /month) as allowable by law.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Adler Family Chiropractic, PC will prepare any necessary reports to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Adler Family Chiropractic, PC will be credited to my account on receipt. I understand that there may be charges associated with preparing and sending reports to either an insurance company or attorney. I also understand and agree that all services rendered to me are charged directly to me and I am personally responsible for the payment. I understand and agree to pay all collection costs, court costs, and /or attorney fee if any delinquent balance is placed with an agency for collection, suit, or other legal action. All outstanding balances will be subject to 1.5% compounded monthly finance charge. *I also agree and understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.*

Patient Name _____ Responsible Party_____

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ 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)

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ADLER FAMILY CHIROPRACTIC, PC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Adler Family Chiropractic, PC to use the following information, but not limited to: my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, recall ("We haven't seen you") cards, using your name or image of you (or dependent) on our message board or Digital Messenger video system for purpose of internal testimonial or referral thank you, sending newsletters, leaving voicemail or e-mailing.
- If Adler Family Chiropractic, PC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

▪ (OPEN ROOM ADJUSTING AUTHORIZATION)

- I give Adler Family Chiropractic, PC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Adler Family Chiropractic, PC permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Adler Family Chiropractic, PC. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Adler Family Chiropractic, PC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Adler Family Chiropractic, PC will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Personal Representative _____
(Guardian)

Description of Representative's
Authority To Act for Patient: _____