Natural Way Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Legal name (first and last) _____

Nickname or name you preferred to be called _____

DOB _____ **Age**_____ **SSN** _____

Gender _____ **Preferred pronouns (optional)** _____ **Marital Status** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email Address _____

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?_____

Is your visit due to a car accident or work injury? (circle one) 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 (if any of the following are relevant to your medical history, please circle all that apply)

Cancer	Muscular	Rheumatic Fever	Digestive Disorders	Diabetes
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Hepatitis
Tuberculosis	Convulsions	Nervousness	Backaches	German Measles
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 _____

Have you ever had massage therapy? (circle) Yes No Date of last massage _____

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 co-issued 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 Natural Way 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 Natural Way 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** _____

NATURAL WAY
CHIROPRACTIC
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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: Natural Way 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:. 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.

Patient Care Services: 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.

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, Natural Way 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 Natural Way Chiropractic will be credited to your account upon receipt.

Appointments: Our office sends email and text appointment reminders, however, they are a courtesy only and not to be relied on. Please call our office as soon as possible if you are not going to make your scheduled appointment. 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. For massage therapy services, our office has no show/late cancellation fees if we fail to receive 24 hours notice prior to your appointment as well as late arrival/early departure fees. Fees are dependent on the service and length of time you were scheduled.

Identification Policy: Natural Way 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 Natural Way Chiropractic clinic policies and agree to honor them:

Patient's Signature _____ Date _____

Printed name if signed on behalf of patient _____ Relationship _____

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PRIVACY PRACTICES AND RELEASES

Our doctors take your healthcare seriously and find it extremely important to keep your primary care provider up to date on your care in our offices. Please provide us with the name and location of your PCP and we will send them your current exam findings and any other requested information.

Primary Care Provider: _____

Location/Office: _____

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.

Name: Relationship:

_____

_____

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 Natural Way Chiropractic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

FOR OFFICE USE:
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
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

_____
Patient's signature Date

_____
Printed name if signed on behalf of patient Relationship

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INFORMED CONSENT

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, cold application, and manual muscle therapy) are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are **extremely** rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs and spinal fractures.

Therapeutic procedures (including massage therapy, cold application, and heat application) are considered safe and effective methods of care. Draping will always be utilized , and only the body part being worked on will be exposed if necessary. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms.

I understand it is my responsibility to let my massage therapist know of any pain or discomfort I am having during the session, or if I'd like the pressure to be less or more at any time. I have also notified my massage therapist of all known medical conditions and injuries. I also understand this is a doctor's office and that my massage is entirely therapeutic and non-sexual in nature.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. By signing this release, I hereby waive and release my provider for any and all liability, past, present and future relating to chiropractic, massage therapy, and bodywork.

Patient's Signature _____ Date _____

Print Patient's Name _____ DOB: _____

Printed name if signed on behalf of patient _____ Relationship _____

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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 they believe 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 Natural Way Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Natural Way 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 Natural Way Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Natural Way 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 Natural Way Chiropractic, PS 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 co-pay, 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

OFFICE USE ONLY
Pt. ID: _____ DOB: _____

□ 99204 □ 99214

□ Merge SOAP notes selected

PCP Referral? □ Yes

DUD/Rivermead □ Yes □ No

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PERSONAL INJURY HISTORY FORM

1. Name: _____ Today's Date: (_____/_____/_____)

2. Date of Accident: (_____/_____/_____). What time was the accident? _____(am/pm)

3. Weather Conditions? □ sunny □ clear □ drizzling □ rainy □ foggy □ snowy □ cloudy □ partly cloudy □ stormy

4. How were the road conditions? □ dry □ damp □ wet □ snowed over □ iced over □ dry with ice patches

5. Do you have a lawyer for this claim? □ No □ Yes, If yes, who? _____

6. Vehicle you were in: Year _____ Make _____ Model _____

7. Type of your vehicle: □ sports car □ coupe □ sedan □ SUV □ station wagon □ pickup truck □ bus
□ Other _____

8. Vehicle size: □ compact □ mid-size □ full-size

9. Place you were seated in the vehicle: □ driver □ front passenger □ back passenger driver side
□ back passenger right side □ back passenger middle

10. If you were the driver, was your foot on the brake? □ Yes □ No □ N/A

11. Actions of patient's vehicle: □ crossing intersection □ stopped at an intersection □ stopped for traffic
□ stopped for pedestrian □ traveling at posted speed limit □ traveling faster than the posted speed limit □ turning

12. How was the patient's vehicle hit? □ was rear ended □ hit head on □ was hit on the left front □ was hit on the right front □ was hit on the left rear □ was hit on the right rear □ Other _____

13. Did you have a safety belt on? □ Yes □ No Shoulder strap? □ Yes □ No

14. Is your car equipped with Airbags? □ No □ Yes, If yes, did airbags deploy? □ Yes □ No

15. What direction were you going? (N, E, S, W) other: _____

16. What street was the accident on? _____ Nearest cross street? _____

17. How fast were **you** going at time of accident? _____ MPH

18. Did any part of your body strike any part of the vehicle? □ No □ Yes, If Yes, please explain:

_____

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19. Does your vehicle have a headrest? □ Yes □ No

20. What part of your body is the top of your headrest located? □ Neck □ Middle of your head
□ Even with the top of your head □ Above top of your head □ Other _____

21. How aware were you at time of impact? □ not aware □ partial □ very □ Other _____

22. Please explain in detail how the accident happened. _____

_____

_____

_____

DESCRIBE THE MOMENT OF IMPACT

23. What position was your **body** at time of impact? □ straight □ leaning forward □ slouched down in seat
□ turned to the left □ turned to the right □ bent left □ bent right □ Other _____

24. What direction was your **body** thrown at time of impact? □ backward then forward □ forward then backward
□ to the left □ to the right □ outside the vehicle □ under the vehicle □ Other
_____

25. What position was your **head** at time of impact? □ straight □ tilted forward □ bent left □ bent right,
□ twisted/rotated to left □ twisted/rotated to the right □ tilted up □ Other _____

26. What direction was your **head** thrown at time of impact? □ backward then forward □ forward then backward
□ side to side □ Other _____

27. Did you feel or hear a popping, tearing, or a ripping noise in your neck or back? □ No □ Yes, If Yes, please explain: _____

_____

28. Did your vehicle strike another vehicle? (was a 3rd vehicle involved): □ No □ Yes, If Yes, please explain:
_____

29. Was the vehicle you were in totaled? □ Yes □ No □ Most likely □ Unknown

30. What is the estimated cost of damage of the vehicle you were in? $_____ □ Unknown

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31. What is the **second** vehicle: Year _____ Make_____ Model _____

32. **Describe** the **second** vehicle: □ compact □ full-size □ mid-size □ bus □ pick-up truck □ semi-trailer

33. What direction was the **second** vehicle going at time of impact? (N, E, S, W) Other: _____

34. How fast was the **second** vehicle going at time of impact? _____ MPH

35. **Describe 3rd** vehicle (If applicable): □ compact □ full-size □ mid size □ bus □ pick-up truck □ semi trailer

36. **3rd vehicle** information (if applicable): Year _____ Make_____ Model _____

AFTER THE ACCIDENT:

37. Did the police come to the accident? □ Yes □ No Was a police report filed? □ Yes □ No □ N/A

38. Were traffic tickets issued? □ No □ Yes, If Yes, to whom: □ you □ the other driver □ the driver of your vehicle

39. Did you lose consciousness after impact? □ No □ Yes, If Yes, please explain: _____

_____

40. After the accident were you: □ stunned □ shook up □ shocked □ other:_____

If so, for how long? _____

41. Did you feel any pain? □ No □ Yes, If Yes, where? _____

_____

_____

42. How soon after the accident did you feel pain? _____

43. Is your pain worse in the: □ AM □ PM □ Constant □ Same Throughout

44. Did you, or have you had any numbness, tingling or pain going down your arms, hands, legs or feet since the accident? □ No □ Yes, If Yes, explain: _____

_____

45. Did you notice any bruising? □ No □ Yes, If Yes, where? _____

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46. Did you take an ambulance to the hospital after the accident? □ No □ Yes, If Yes, what hospital?

_____

47. If you did go to the hospital what procedures were done? □ Exam □ X-Rays □ MRI □ CT
□ Chiropractic Referral □ Physical Therapy Referral □ Massage Therapy Referral
Other? _____

48. Were you examined by another healthcare professional after the accident? □ No □ Yes

If Yes, by whom? _____ When/Date? _____

49. What was done? □ Chiropractic Referral □ Physical Therapy Referral □ Massage Therapy Referral
□ Other? _____

50. Were you prescribed any medication? □ No □ Yes, If Yes, what kind(s)?_____

51. Was a diagnosis given? □ No □ Yes, If Yes, what did they diagnose you with? _____

52. What have you tried to make your symptoms better? □ ice □ heat □ stretch □ exercise □ massage
□ Other:_____

53. What do you do that make your symptoms worse? _____

54. Have you missed work as a result of this accident? □ No □ Yes, If Yes, how many days? _____

55. What is your occupation? _____

56. What duties are required of you on the job? _____

_____

57. Have you ever seen a chiropractor? □ No □ Yes, If Yes, when and who?

_____

58. Have you ever had spinal X-rays? □ No □ Yes, If Yes, when and where?

_____

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59. What are your current symptoms? □ Headaches □ Migraines □ Neck Pain □ Upper back pain

□ Shoulder pain (□ Left □ Right □ Both) □ Mid back pain □ Low back pain □ Hip Pain (□ Left □ Right □ Both)

□ Knee pain (□Left □ Right □ Both) □ Arm/hand pain and tingling (□ Left □ Right □Both)

□ Leg/foot pain and tingling (□Left □ Right □ Both)

60. Compared with **before** the accident, do you **now** suffer from: □ Mood changes □ Feelings of dizziness

□ Nausea and/or vomiting □ Noise sensitivity □ Sleep disturbance □ Fatigue □ Forgetfulness □ Poor Memory

□ Poor concentration □ Taking longer to think □ Blurred vision □ Light sensitivity □ Restlessness

□ Feeling depressed or tearful □ Feeling frustrated or impatient □ Being irritable □ Easily angered

□ Ringing in the ears □ Lack of energy □ Difficulty sleeping □ Seeing stars

□ Other, please explain: _____

_____

_____

BELOW IS FOR OFFICE USE ONLY

Patient is concerned and now seeking the necessary massage therapy and chiropractic care.

SUBJECTIVE COMPLAINTS

P1: _____ O_____ F_____ D _____ I _____ /10

P2: _____ O_____ F_____ D _____ I _____ /10

P3: _____ O_____ F_____ D _____ I _____ /10

P4: _____ O_____ F_____ D _____ I _____ /10

P5: _____ O_____ F_____ D _____ I _____ /10

Enter Dragon Disclaimer