CONFIDENTIAL PATIENT INFORMATION

FULL NAME: _____ **DOB**: ___/___/____ **AGE**: ____ ☐ Male ☐ Female

ADDRESS: _____ APT#: _____ **SSN**: _____ - _____ - _____

CITY: _____ **STATE** _____ **ZIP CODE** _____ **HOME PHONE** (____) _____

CELL PHONE: (_____) _____**EMAIL ADDRESS**: _____

WHICH METHOD IS THE BEST TO REACH YOU? ☐ Cell ☐ Home ☐ Email ☐ Work: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Other **DATE SYMPTOMS BEGAN:** _____/_____/_____

EMPLOYER'S NAME: _____ **OCCUPATION**: _____

RACE: ☐ White ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Korean

☐ Hispanic ☐ Other:_____ ☐ I choose not to specify

ETHNICITY: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ I choose not to specify

PREFERRED LANGUAGE:_____ **HOW DID YOU HEAR ABOUT US?**_____

EMERGENCY CONTACT: _____

RELATIONSHIP:_____ **PHONE**: _____

CURRENT CLAIM INFORMATION:

IS YOUR CONDITION DUE TO: ☐ Auto Accident ☐ Work Injury

I HAVE OPENED A CLAIM: ☐ Yes ☐ No

WHAT WAS YOUR DATE OF INJURY: _____/_____/_____ **WHAT IS YOUR CLAIM #:**_____

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

INSURED'S FIRST AND LAST NAME _____ **INSURED'S DOB** _____/_____/_____

PRIMARY INSURANCE CO. _____

AUTHORIZATIONS

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from their-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C . I understand and agree that health and accident 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 making 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. 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. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

D. I understand that if I opt out of using my insurance or have no insurance that all services rendered to me are charged directly to me and that I am personally responsible for payment. If you have inability to pay, a payment plan can be arranged.

E. NSF checks or rejected payments will be charged a service fee of $20.00 per occurrence.

Patient's Signature: _____ **Date**: _____

Guardian Signature: _____ Date: _____

Informed Consent to Care

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. The health assessment/ x-ray process is designed to provide essential information we need to give you the best possible health care. In rare instances the health assessment/ x-ray process can cause exacerbations or new injury. We have an excellent safety record and will take every possible precaution to protect your health. By signing this form you are authorizing the use of x-rays if medically necessary. If you choose to decline any x-ray procedure, or are pregnant, please notify the front desk immediately. If you are pregnant, be advised that x-rays can be hazardous to an unborn child; by signing this form you acknowledge the above information and have truthfully informed 360 Chiropractic if you are pregnant. Please note that refusal of x-ray could impact the doctors ability to treat you.

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, burns and/or scarring from electrical stimulation and from hot or cold therapies, 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 a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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: _____

Witness Name: _____ Signature: _____ Date: _____