Superior Chiropractic and Wellness

Patient Information

Name:_____ Today's Date:_____

Address:_____

City:_____ State:_____ Zip:_____ Cell Phone:_____

Work Phone:_____ Social Security Number:_____ Date of Birth:_____

Marital Status:_____ Spouse's Name:_____

Email:_____ How did you hear about us?:_____

If referred, who referred you to our office?:_____

Employer's Name and Address:_____

Primary Care Physician Name:_____ Clinic:_____

Phone:_____ Address:_____

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1)_____

2)_____

3)_____

List approximately how long you have noticed these problems:

1)_____

2)_____

3)_____

Is there a certain time of day any of these problems are better or worse?

_____

_____

List the treatments you have used for these problems:

□ Ice □ Heat □ Exercise □ Massage □ Chiropractic □ Rest

□ Physical Therapy □ Medication(s):_____

_____

□ Other:_____

Describe any sudden movements, injuries, falls, accidents, etc. that have caused your problem(s):_____

_____

Have you had similar health problems or injuries before? □Yes □No

Did you receive: X-Rays □ Yes □ No Date:_____ MRI □ Yes □ No Date:_____

Have your health problems: □ Improved □ Worsened □ Stayed the Same

List anything that makes your conditions worse: _____

List anything that makes your conditions better: _____

Please check off and describe how this problem interferes with your work and/or personal life:

□ Work Activities Effected: _____

Have you missed any days of work? □Yes □No If yes, dates missed: _____

□ Home Activities Effected: _____

□ Recreational Activities Effected: _____

Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily: ____

Do you drink? □ Yes □ No If yes, how many drinks/week: ____

Do you exercise regularly? □ Yes □ No If yes, describe what type and how often: _____

_____

Do you consider yourself to have a good social support system (friends/family)? □ Yes □ No

Describe a typical daily diet (fast food/home cooked/vegan/gluten free/specific diet plan/etc.):

_____

Review of Systems

Check any symptoms you've had in the past year:

□ Muscle Pain	□ Fever	□ Chills	□ Fatigue	□ Eye pain	□ Blurred vision
□ Double vision	□ Headaches	□ Joint swelling	□ Nosebleed	□ Ringing in ears	□ Chest pain
□ Skin changes	□ Fainting	□ Wheezing	□ Chest tightness	□ Anxiety	□ Heartburn
□ Nausea	□ Vomiting	□ Constipation	□ Diarrhea	□ Bloody stool	□ Joint stiffness
□ Difficult/ painful urination	□ Unexpected weight loss or gain	□ Difficulty swallowing	□ Heart Palpitations	□ Poor wound healing	□ Shortness of breath
□ Depression	□ Tremors	□ Seizures	□ Easy bleeding/ bruising	□ Excessive thirst or urination	□ Allergic Reactions
□ Tingling	□ Numbness	□ Sleep Disorder			

Past Health History

During the last year, has a doctor treated you for any health problem? □Yes □No

If yes, please explain:_____

_____

Please check the prescription drugs you are currently taking: □Anti-depressants □Anti-Inflammatory

□ Birth Control Pills □ Blood Pressure Pills □ Diet Pills □ Blood Sugar Medication

□ Muscle Relaxers □ Insulin □ Pain Pills □ Sleeping Pills

□ Aspirin □ Tylenol □ Motrin □ Alleve □ Advil

□ Other (please list):_____

List any vitamins or nutritional supplements you are currently taking or have taken recently:

_____

List the approximate dates of any surgeries, serious injuries, or accidents (including broken bones) you have had:

_____

_____

Please list any chronic health problems that run in your family:

_____

_____

Financial Responsibility

Who is responsible for your bill? □ Insurance □ My Employer □ Spouse □ I am

□ Other:

Type of Insurance: □ Automobile □ Health □ Worker's Comp

Insurance Company's Name, Address and Phone #: _____

_____

Your fees are due and payable at the time examination, X-rays and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature:_____ Date: _____

Parent or Guardian Signature (if patient is minor)

_____ Date:_____

Patient-Clinic Agreement

The purpose of this agreement is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreement get the best results.

What to Expect from us

You can expect a friendly staff, timely appointments, state-of-the-art care and we will always be your partner in health.

Visit Expectations (How to make appointments efficient)

1. Please be respectful to other patients and our staff by being on time for your appointment. If you are going to be late, please call our office.
2. Verbally check in at the front desk. If you are waiting for longer than 15 minutes, please let us know.
3. Schedule future visits in advance.

Missed Appointments

If for any reason you cannot keep an appointment, please telephone *immediately*. * MISSED OR CANCELLED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE FOR CHIROPRACTIC WILL INCUR A $50.00 FEE. *** MISSED OR CANCELLED APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE FOR PHYSICAL THERAPY WILL INCUR A $100.00 FEE. *** It is your obligation to make up a missed appointment within 7 days to stay current in your care plan.**

Payment of Bills

- We expect you to honor the financial agreement you make with our office. If you find that you cannot fulfill the agreement that you have made with us, please notify our staff immediately.
- Any deductible or co-pay must be paid at the time of service.
- If your insurance company is not responding to our claims in a timely manner (60 days) please call and/or write them to assist with collections for services rendered.
- If your insurance company deems that services are not medically necessary, *you will be responsible for any unpaid balance*.

There is a $25 processing fee added to any account for any returned check. We accept payment by Visa, MasterCard, American Express and Discover.

Results

Your results are positively influenced by adhering to our recommendations. If you are unhappy with your results, we respectfully request that you share your feelings so that we may resolve any of your concerns.

I have read this outline and I understand and accept these policies.

Patient Name (Please Print) _____

Patient 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 but may be uncomfortable.

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 an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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:

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**