GROW IN HEALTH

FLOURISH

Name: _____ Date: _____

FIRST LAST

Birthdate: ___-___-_____ Age:_____

Mailing Address: _____

_____

CITY STATE ZIP

Home Phone(___)___-_____ Cell Phone(___)___-_____

E-mail Address: _____

Referred By: _____

Employer/School: _____

Occupation: _____

Preferred Contact Method/ Reminders:

☐ Text ☐ Email

Preferred Payment Method:

☐ Insurance ☐ Cash ☐ Credit

Health Status:

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Chronic condition ☐ Wellness

Are you in pain: ☐ Yes ☐ No Rate you pain: *discomfort* 1 2 3 4 5 6 7 8 9 10 *intense*

Did your injury occur during: ☐ Work ☐ Sports/Play ☐ Auto Accident ☐ Routine/Household activity

When did your condition/accident occur? _____ Where did your injury occur?_____

Please explain what happened: _____

_____

In your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and goes.

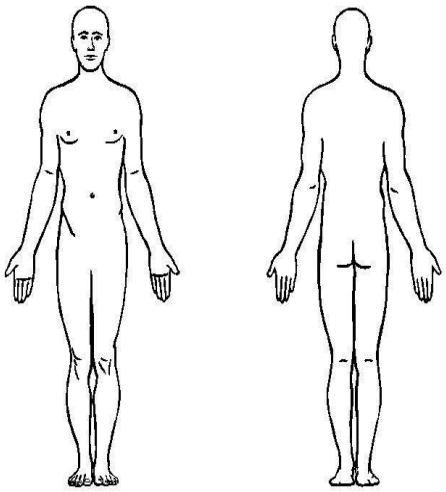
In your condition interfering with your: ☐Work ☐Sleep ☐Daily Routine?

If so, how: _____

Has this or something similar happened in the past? ☐Yes ☐No

Explain: _____

Using the adjacent body chart, please circle all affected areas.



Type of pain with: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

Any pain? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Have you been treated by a Medical Physician for this condition?☐ Yes ☐ No

If so, where? how? _____

Have you ever been treated by a Chiropractor? ☐ Yes ☐ No Doctor: _____

Health History

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐None ☐ Other:_____

Please circle "Y" for yes and "N" for no to indicate if you have had any of the following:

Y N Cardiac Problems	Y N Liver Disease	Y N Anemia/ Diabetes	Y N Hepatitis	Allergies
Y N Kidney Problems	Y N Alcohol/ Drug Abuse	Y N Arthritis	Y N Cancer	_____
Y N Shingles	Y N HIV+ / AIDS/ ARC	Y N Frequent Neck Pain	Y N Fainting/Seizures/ Epilepsy	_____
Y N Blood Pressure Issues	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe/ Frequent Headaches	_____
Y N Ulcers/ Colitis	Y N Glaucoma	Y N Sinus Problems	Y N Emphysema/ Asthma	_____
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/ Implants	_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day: _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/ Week: _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day:_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason: _____

Dietary Restrictions: ☐ No ☐ Yes: _____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports

For women: Cycle Length: _____ Days

Are you taking Birth Control? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No

Are you Pregnant? ☐Yes ☐No If so, how many weeks?_____

List any past injuries/surgeries:	DESCRIPTION	DATE
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Are you taking of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Insulin ☐ Muscle relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Other(s): _____PLEASE LIST BELOW_____

Please list: MEDICATIONS/ VITAMINS/ HERBS/ MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ We invite you to ask us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

❖Our policy requires payment in full for all services at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

❖I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❖I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of my changes to the information I have provided.

Signature _____ Date:_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Cancellation & No-Show Policy

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need for care.

Please be aware that a $50.00 cancellation fee will be assessed if you are a no-show or fail to cancel with in 24 hours of your appointment.

Our chiropractic appointments generally take 20 + minutes. If you arrive more than 15 minutes late, this will count as a missed appointment.

In the case of an unavoidable emergency, this fee may be waived. If you have any questions, don't hesitate to ask.

Please sign below to acknowledge your understanding of our cancellation policy.

Name: _____ Date: _____

Signature: _____

Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use her hands or a mechanical device to manipulate the area treated. You may feel or hear a “click” or “pop,” and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increase pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one’s health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.

Other options for the treatment of pain include: do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and you may use the space below for this purpose.

_____

_____

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has hold me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also I have fully disclosed to my chiropractor my medical history regarding the above specified complication factors and all other conditions that have caused me pain in the past.

Patient Name	**Signature**	**Date**
Parent / Guardian Name	**Signature**	**Date**
Flourish SC Witness Name	**Signature**	**Date**

FLOURISH SC

~ COLLABORATION NOTICE ~

Here at Flourish SC, practitioners in the office often collaborate with one another. We do this in effort to provide the best patient care. We will only share what we believe to be relevant to your care. We would like your permission to do so. Please sign below acknowledging this notice and to accept.

Name: _____ Date: _____

Signature: _____

HIPAA COMPLIANCE AUTHORIZATION PATIENT CONSENT FORM

Flourish - Grow in Health

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice. I acknowledge that I have received a HIPAA Compliance Assurance Notification.

Print Name: _____

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative Name: _____

Relationship to the Individual: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!