Patient Information

Name: ____ Date: _______________

Birthday: _______________ Age: ______ Sex: ____ Marital Status: ________________

Address: ____ City: _______________________

State: ______ Zip: ____________ Email: ______________________________________

Home Phone: (_____)_____-_______ Cell Phone: (_____)_____-_______

Preferred Contact: ( ) Home Phone ( ) Cell Phone ( ) Email

Appointment Reminders: ( ) Cell Phone Carrier:__________________ ( ) Email

Occupation: ________________________________ Employer: __________________________________

Emergency Contact: _____________________________________ Relation: _____________________

Phone Number: (_____)_____-_______ Other: (_____)_____-_______

Primary Complaint

Reason for Visit: ____

When did these symptoms start? ____

How often does this symptom occur? ____

Rate your pain on a scale from 1 (least pain) to 10 (severe pain): ________________________________

Is the symptom getting progressively worse? ( ) Yes ( ) No ( ) Unknown

Type of pain: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting

( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling ( ) Other

Is the pain constant or does it go away? ____

Does it interfere with your ( ) Work ( ) Sleep ( ) Daily Routine ( ) Recreation

Activities that are painful ( )Sitting ( )Standing( ) Walking( ) Bending( ) Lying Down ( )Transitions

Accident Information

Is this condition due to an accident? ( ) Yes ( ) No Date: __________________

Type of accident ( ) Auto ( ) Work ( ) Home ( ) Other

To whom have you made a report of your accident?

( ) Auto Insurance ( ) Employer ( ) Worker Comp. ( ) Other

Attorney Name (if applicable): ____

Health History
Current Health Problems: ____
____
Significant Family Health Problems: ____
____
Exercise: ( ) None ( ) Moderate ( ) Daily ( ) Heavy
Work Activity: ( ) Sitting ( ) Standing ( ) Light Labor ( ) Heavy Labor
( ) Smoking packs/day__________ ( ) Alcohol drinks/week __________ ( ) Stress Why?__________
Injuries: ____
Surgeries: ____

Medication	Allergies	Supplements
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Informed Consent

Chiropractic

It is important to you, the patient, to recognize the difference between chiropractic and the practice of medicine. They both may be important to your health, but for different reasons. Chiropractors seek to restore health though natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the chiropractor in his efforts. A chiropractor's services are based upon his efforts to promote the natural flow of energy in the patient's nervous system. His objective is to give the body maximum opportunity to heal itself. The success of these procedures is often dependent upon underlying causes and conditions. It is important you understand what to expect of chiropractic, and how is differs from medical services in order that you, the patient, can better determine whether either or both may be of benefit to you.

Analysis

A chiropractor conducts a chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxations. Subluxations result from misalignment of the spinal column. When subluxations are found, chiropractic adjustments are given in an effort to restore proper spinal alignment. Due to the complexities of nature, no chiropractor can promise or guarantee you a specific result. This is often dependent upon the recuperative powers of your body. However, it is the chiropractic premise that spinal alignment allows free nerve flow throughout the body and gives the body its best chance to restore health.

Chiropractic analysis is the basis for chiropractic service. Chiropractors do not claim superiority in the field of medical diagnosis. Diagnosis is a medical specialty and one which is practiced as a specialty by medical internists. The patient is a reminded that the chiropractic analysis is not an effort to diagnose. If diagnosis is of vital concern, the patient may wish to request referral to a specialist. Certainly, every patient must be aware of his own symptoms and should secure a second opinion is he has concern as to the nature of his illness or injury. This is the right and shared responsibility of the patient regardless of any diagnostic opinion which might be expressed by or elicited from the doctor of chiropractic.

Chiropractic adjustments

The patient, is coming to the chiropractor, given the chiropractor permission and authority not only to examine the patient, but to adjust the patient in accordance with the chiropractors' analysis. The chiropractic adjustment is given for the benefit of the patient. Such adjustments are usually beneficial and seldom cause problems. In rare cases, unknown physical defects, deformities, or disease may render the patient more susceptible to injury than would be the case had these underlying problems been known. The chiropractor of course, will not give a chiropractic adjustment is he is aware that such conditions exist. Again, it is the responsibility of the patient to ascertain whether he is suffering from any latent pathological effects, illness, or deformities which might cause chiropractic adjustments to be contraindicated. It is then the responsibility of the patient to make this known to the chiropractor. A patient should never rely upon a doctor of chiropractic for in-depth diagnostic procedures. The doctor of chiropractic provides a specialized health service and does not become involved in the patient's medical regimen. Chiropractors do not prescribe or dispense drugs or medicines. A patient should not ask for or rely upon the advice of a chiropractor concerning the taking pf prescriptive medicines.

Results

The purpose of chiropractic services is to promote natural health through the maximum release of nervous energy. Since there are so many variables, it is most difficult to predict the times schedule of efficacy of chiropractic procedures. Sometimes response is immediate and long-lasting. In many cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are mediocre or dismal. Sometimes what appear to be similar conditions may respond quite differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. We must also recognize that some conditions which do not respond chiropractically may come under control or be cured through medical science. The fact is that the sciences of chiropractic and medicine may never be so exact as to provide definite answers to all health problems. Both have made great strides in alleviating pain and controlling disease.

Questions

You as the patient should feel free to discuss any questions or problems with the doctor prior to undergoing chiropractic care. You are encouraged to continue to ask questions throughout the duration of your care.

Acknowledgment

I have read the forgoing six paragraphs and understand them. Sign this ____________ day of ________________________ , 20 _____.

Signature:__________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

Acknowledgment of Receipt of this Notice as a patient of Agape Family Chiropractic LLC, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Agape Family Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: ____

Signature of Patient: ____Date: __________________

Authorization to Release Information

Please indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

□ Spouse: _______________________________ □ Yes, Health Info □ Yes, Billing Info □ Yes, Scheduling

□ Parent/s or Guardian/s: ________________________________

□ Yes, Health Info □ Yes, Billing Info □ Yes, Scheduling

□ Relative/Friend/Other: ___________________________Indicate Relationship: ___________________

□ Yes, Health Info □ Yes, Billing Info □ Yes, Scheduling

Signature of Patient: _________________________________ Date: ______________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgment
- □ Other (please specify)

  ____
  ____
  ____

Consent For Imaging Studies

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document.

Your condition may require additional diagnostic studies including but not limited to diagnostic x-rays. These are ordered so that your doctor can provide you with the best possible care. Before you consent to any additional study, your doctor will explain the benefits and risks associated with the procedure. Body exposure to ionizing radiation is associated with increased risk for developing genetic mutations or cancer. The dosage utilization in producing x-rays is very minimal, well below the dosage documented to have negative impact on a person's health. However, as these effects are cumulative over a lifetime, your doctors strive to minimize your exposure by using state of the art equipment and protocols. The benefits of having these images available to better understand your health status outweigh the minimal risks associated with the exposure and have been assessed by your doctor.

** DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE OPTION AND SIGN BELOW

I have read ( ) or have had read to me ( ) the above explanation of x-ray studies.

I have discussed it with Dr. Orris and have had my questions answered to my satisfaction.

By signing below, I state that I have weighed the risks involved in undergoing the recommended x-rays and have decided that it is in my best interest to undergo the procedure recommended. Having been informed of the risks, I hereby give my consent to this procedure.

Signature: ______________________________________ Date:______________________________
Print Patient's Name:_____________________________________

I authorize the x-rays to be taken of ________________________________ (minor child) as duly authorized in this form.

Signature_____________________________________ Relationship:___________________________

Pregnancy Release: (Females Only)
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised x-ray can be hazardous to an unborn child.

Pregnancy tests are available upon request if there is a chance that you may be pregnant.

☐ Yes, I wish to take the test. ☐ No, I do not wish to take the test.

Pregnancy tests result:
☐ Positive ☐ Negative

Date of last menstrual period: ____________________

Signature:_________________________________ Date:____________

Financial Office Policy

1. The doctor will give you an estimate of the fees for service before they are performed or rendered.

2. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

3. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.

4. This office accepts MasterCard, Discover, Visa, Cash, Personal Checks, and Health Savings.

5. Any checks denied by our bank will result in a $30 fine.

6. Clients understand that if they wish to stop care prior to utilizing all credits, clients account balance will be prorated based upon the full rate cash visit price of $60 per visit.

7. Clients participating in the 12 month membership who decide to terminate before their 12 months have been completed understand that one more monthly payment will be withdrawn before termination.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Signature:____________________________________ Date:_______________

Cancellation and No Show Policy

Cancellation Policy:

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment at 636-549-9004. This allows us to offer this appointment slot to other patients who may have an immediate need to our care. Of course, we understand emergencies happen and will gladly accommodate any patient if we can. Your health and well-being is always our priority.

No Show Policy:

A "no show" is someone who misses an appointment without canceling it in an acceptable manner. This will result in a fee of $50.00 being billed to the patient's account. "No show" fees are the patient's responsibility and must be paid before your next appointment. The fee cannot be billed to your insurance company.

I have read and understand the Cancelation and No Show Policy and agree to abide by these terms.

Signature:____________________________________ Date:_______________