



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 through 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 it 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 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 if 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, in 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 if 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 of 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 our 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 \$30.00 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 Cancellation and No Show Policy and agree to abide by these terms.

Signature: _____ Date: _____