JACOB FAMILY CHIROPRACTIC

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand I have a right to review Jacob Family Chiropractic's Notice of Privacy Practices prior to signing this document. Jacob Family Chiropractic's Notice of Privacy is displayed in the waiting room. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health operations of Jacob Family Chiropractic.

Jacob Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a reserved copy by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient for Personal Representative

Date

Jacob Family Chiropractic

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain that. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of the force to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.
Vertebral Subluxation: A misalignment of one of more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in ta lessening of the body's innate ability to express it maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual finding, we will advise you. We will recommend you seek the services of a healthcare provider that specializes in that area.

I_____have read and fully understand the above statements.

I understand that all questions regarding the doctor's objectives pertaining to my care in this office will be answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Signature:_____Date:_____

I,_____being the parent or legal guardian of _____have read and fully understand to above terms of acceptance and herby grant permission for my child to receive chiropractic care.

Pregnancy Release: This is to certify to the best of my knowledge I am not pregnant and the above doctor has my permission to perform x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle_____

Signature:_____
Date:_____

Jacob Family Chiropractic
3820 South Lapeer Road
Metamora, MI 48455
(810) 678-2414

Jacob Family Chiropractic

PAYMENT POLICY

There are two forms of payment:

CASH: Pay for each visit at the time of service. After 60 days of non-payment, a $25 late fee will be added to your account to be compounded monthly. Collections will begin after 3 late fees have been accrued.

INSURANCE ASSIGNMENT: Copay, insurance reimbursement signed to our clinic as explained below.

INSURANCE ASSIGNMENT PROGRAM

1. Waiting for an insurance payment is a courtesy provided by this office. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive health care program is recommended. We will notify you of the change.

2. It is your responsibility to supply this office with necessary forms to complete billing if needed.

3. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.

4. ***The clinic does not promise that an insurance company will pay.*** In the event that the insurance company disputes or rejects that claim, it will be the patient's responsibility to pay all charges from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old. After 60 days of non-payment, a $25.00 late fee will be added to your account to be compounded monthly.

5. Collections will begin after 3 late fees have been accrued.

I have read the above provisions and wish to participate in the insurance or cash assignment program. I hereby agree to abide by the provisions as specified above.

Patient Signature:_____ Date:_____

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Welcome!

CONFIDENTIAL CASE HISTORY

Date _____

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate healthcare provider. If you need help with this form, please do not hesitate to ask.

PERSONAL INFORMATION

Name: ❑Mr. ❑Mrs. ❑Ms ❑Miss ❑Dr. _____
How do you wish to be addressed in our office? ❑First Name ❑Mr. ❑Mrs. ❑Ms ❑Miss ❑Dr.
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Business Phone: _____ Cell Phone: _____
Date of Birth month _____ day _____ year _____ Employer: _____
Occupation: _____ Email Address: _____
Marital Status: ❑M ❑S ❑W ❑D Spouse's or Partner's Name: _____
Do you have children? ❑No ❑Yes Children's Names & Ages: _____
How did you hear about our office? _____

HEALTH INFORMATION

Have you ever been to a Chiropractor before? ❑ No ❑ Yes, Doctor's Name: _____
When was your last visit? _____ What was the problem? _____
Have you had previous healthcare for this problem? ❑ No ❑ Yes
When? _____ Where? _____
Were x-rays taken? _____ Date taken: _____

REASON FOR CONSULTING THE OFFICE

- ❑ I have a specific problem and require help only with this problem.
- ❑ After my specific problem has been relieved, I am interested in strategies to ensure the problem does not return.
- ❑ After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
- ❑ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

What is your major complaint? _____
Is this a result of a motor vehicle accident? ❑No ❑Yes
Is this a Worker's compensation Case? ❑No ❑Yes, Social Insurance Number: _____
How long have you had this condition? _____
Have you had this or similar conditions in the past? ❑No ❑Yes, and when? _____
What activities aggravate your condition? _____
What makes it feel better? _____
Is this condition getting progressively worse? ❑No ❑Yes ❑Constant ❑Comes and Goes
Is this condition interfering with your: ❑Work ❑Sleep ❑Daily Routine ❑Other: _____
How long has it been since you really felt well? _____
Has there been any medical diagnosis of your complaint? ❑No ❑Yes, list the Dr.'s name and diagnosis _____
_____

Please complete next page....

On a scale of 1 to 10, 10 being the highest, rate your desire to correct this problem: _____

List surgical operations and years: _____

List any Prescription Drugs, Over the Counter Drugs, Vitamins and Natural Supplements you are currently taking: _____

_____

Do you wear: ❑Heel lifts ❑Sole lifts ❑Inner soles ❑Arch supports ❑Orthotics

Sleeping Posture: ❑Side ❑Stomach ❑Back

Do you do repetitive motions on the job? ❑No ❑Yes, describe: _____

Have you been in an auto accident: ❑Never ❑Past year ❑Past 5 years ❑Over 5 years ago

Description of accident: _____

Have you had any other personal injury or accident: ❑Never ❑Past year ❑Past 5 years ❑Over 5 years ago

Description of accident: _____

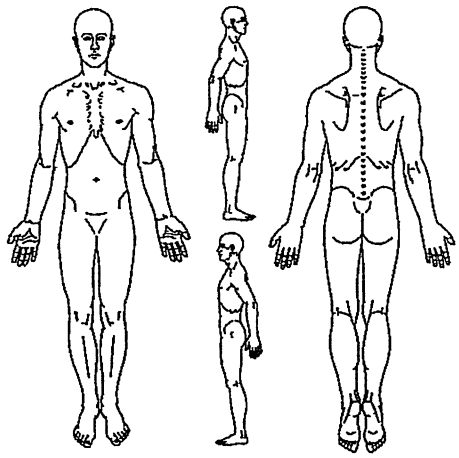
Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:

P - Pain

N - Numbness

S - Spasm

T - Tenderness



Dr. NOTES:_____

_____

_____

_____

Are you affected by any of the following? Please check ❑ O = Occasionally F = Frequently C = Constant

	O	F	C		O	F	C		O	F	C
Neck Pain	❑	❑	❑	Dizziness	❑	❑	❑	Chest Pain	❑	❑	❑
Shoulder Pain	❑	❑	❑	Sinus Trouble	❑	❑	❑	Digestive Upset	❑	❑	❑
Mid Back Pain	❑	❑	❑	Colds	❑	❑	❑	Heartburn	❑	❑	❑
Low Back Pain	❑	❑	❑	Earache	❑	❑	❑	*Females Only:*			
Foot Trouble	❑	❑	❑	Allergies	❑	❑	❑	Painful menstruation	❑	❑	❑
Numbness/Pins &Needles	❑	❑	❑	Asthma	❑	❑	❑	PMS	❑	❑	❑
Headaches/Migraines	❑	❑	❑	Difficulty Breathing	❑	❑	❑	Pregnant Yes ❑No❑			

Emergency Contact Information: In the case of an emergency, whom would you like us to contact? Name & contact #

_____

Patients Signature: _____ Date: _____

We thank you for your patience and cooperation in completely filling out this form.