Route 28 Chiropractic Patient Information

Full Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ SSN: _____

City: _____ State: _____ Zip: _____ Ins. Co. Name: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Employer: _____ Do you smoke?: □No □Yes- how many per day: _____

Are you Hispanic or Latino? □No □Yes *Females:* Are you pregnant? □No □Yes, due date: _____

Race (please check all that apply): □White □African American □Asian □American Indian □Other: _____

Who is your Primary Care Physician? _____

I hereby authorize the following individual(s) access to my protected health information (PHI). I understand that I may rescind this authorization, in writing, at any time. The individuals that are authorized are:

Person	Phone #	Relationship (spouse, sibling, etc…)

_____ _____

Your Printed Name **Your Signature**

Informed Consent To Chiropractic Treatment:

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various adjunct procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, or in rare cases, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment rarely occur, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in a million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also rare.

Other treatment options that could be considered may include over-the-counter analgesics, medical care, hospitalization, and surgery.

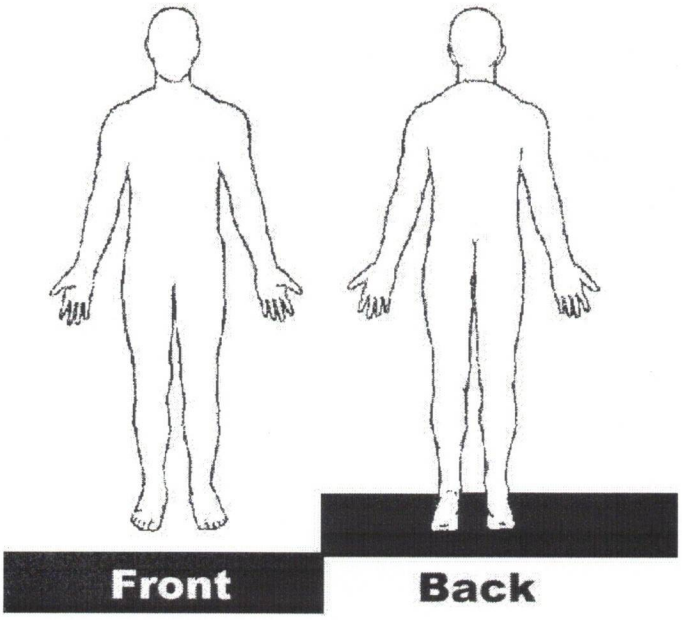
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. The information I have given to the office is truthful. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

Route 28 Chiropractic Symptom Diagram

Circle where you are having pain.



How long have you had this condition? _____

Is it getting worse? □Yes □ No □ About the Same

Please list all surgeries: _____

_____

_____

_____

What medications are you currently taking?

_____

_____

_____

_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	□Yes □ No	**Frequent Cough**	□Yes □ No	**Liver Disease**	□Yes □ No
Anaphylaxis	□Yes □ No	**Frequent Diarrhea**	□Yes □ No	**Low Blood Pressure**	□Yes □ No
Anemia	□Yes □ No	**Frequent Headaches**	□Yes □ No	**Mitral Valve Prolapse**	□Yes □ No
Angina	□Yes □ No	**Genital Herpes**	□Yes □ No	**Pain in Jaw**	□Yes □ No
Arthritis/Gout	□Yes □ No	**Heart Attack**	□Yes □ No	**Psychiatric Care**	□Yes □ No
Artificial Heart Valve	□Yes □ No	**Heart Failure**	□Yes □ No	**Radiation Treatment**	□Yes □ No
Artificial Joint	□Yes □ No	**Heart Murmur**	□Yes □ No	**Recent Weight Loss**	□Yes □ No
Blood Disease	□Yes □ No	**Heart Pacemaker**	□Yes □ No	**Shingles**	□Yes □ No
Blood Transfusion	□Yes □ No	**Heart Disease**	□Yes □ No	**Sinus Trouble**	□Yes □ No
Cancer	□Yes □ No	**Hemophilia**	□Yes □ No	**Spina Bifida**	□Yes □ No
Chest Pains	□Yes □ No	**Hepatitis A**	□Yes □ No	**Stroke**	□Yes □ No
Diabetes	□Yes □ No	**Hepatitis B or C**	□Yes □ No	**Swelling of Limbs**	□Yes □ No
Drug Addiction	□Yes □ No	**High Blood Pressure**	□Yes □ No	**Thyroid Disease**	□Yes □ No
Emphysema	□Yes □ No	**Hives or Rash**	□Yes □ No	**Tuberculosis**	□Yes □ No
Epilepsy/Seizures	□Yes □ No	**Irregular Heartbeat**	□Yes □ No	**Tumors/Growth**	□Yes □ No
Fainting Spells	□Yes □ No	**Kidney Problems**	□Yes □ No	**Ulcers**	□Yes □ No

Name:_____ DOB: _____ Date:_____

Route 28 Chiropractic
1240-B State Route 28
Milford, Ohio 45150
(513) 575-5444

Patient Acknowledgement and Receipt of Notice of Privacy Practices

Pursuant to HIPAA,

Consent for Use of Health Information,

Financial Responsibility

I hereby acknowledge receipt of the Notice of Privacy Practices for Route 28 Chiropractic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Route 28 Chiropractic and Bryan F. Walther, D.C., and my respective rights contained therein. I also understand that the notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this notice at any time by contacting Bryan F. Walther, D.C. (513) 575-5444.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Authorization for Billing Insurance and Financial Responsibility

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. The undersigned agrees that if this account is not paid when due, and Route 28 Chiropractic/Bryan Walther D.C. should retain an attorney or collection agency for collection, the undersigned agrees to pay all costs of collection including court costs, reasonable interest, reasonable attorney's fees and reasonable collection agency fees. I fully understand I am solely responsible for any balance not paid by my insurance company or other entity. I understand that once insurance has been billed, Route 28 Chiropractic/Bryan Walther D.C. is unable to make any adjustments to the amount of my bill. Any unpaid balance of 60 days past due or greater may be subject to a monthly interest rate of 1.5% (18% APR) in addition to a $7.00 statement fee.

_____ **(initial)** *I understand it is the policy of this office NOT to bill massage therapy services or Extracorporeal Shock Wave Therapy (ESWT) to specific insurance companies including, but not limited to, Medicare and all Supplemental Plans, Medicaid, Aetna, Cigna, United Healthcare, UMR, Anthem BCBS, Humana, etc. I may still receive these services at a time-of-service rate, meaning payment is due at the time of service.*

_____ ***(initial)*** *I understand exams and other therapeutic modalities are not covered by Medicare and/or Medicare Supplemental Plans.*

_____ **(initial)** *The office may utilize text messaging to notify patients of appointments and account balances. I authorize the office to contact my cellphone via text messaging.*

_____	_____	_____
Printed Name	*Signature*	*Date*

If patient is a minor or under a guardianship order as defined by state law, a parent or guardian should sign below:

_____
Signature of Parent/Guardian