

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: _____

Emergency Contact and Phone #: _____

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? _____

Do you or an immediate family member have the following conditions?

	NO	YES	FAMILY MEMBER:
Rheumatoid Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALS?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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.

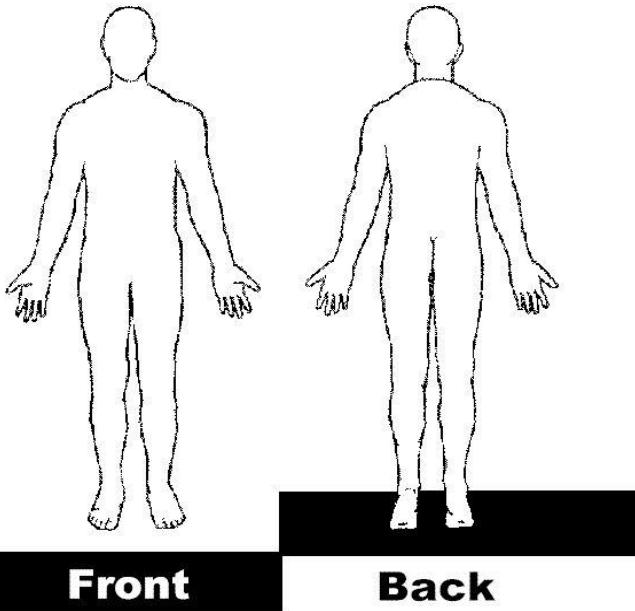
Printed Name

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

_____ **(initial)** *I understand it is the policy of this office NOT to bill massage therapy services 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)** *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