Prater View Chiropractic and Health Clinic

PERSONAL HISTORY

First Name _____Middle Initial_____ Last Name _____ Date _____

Mailing Address _____

City_____ State_____ Zip _____

Date of Birth_____ Age_____ Sex: □ Male □ Female Marital Status: □ M □ S □ D □ W □ SEP

Social Security _____E-mail Address _____

Home Phone #_____Cell Phone # _____

Race (Circle one): American Indian / Asian / African American / White (Caucasian) / Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Employer _____ Occupation: _____

Address _____

City_____ State_____ Zip _____

Work Phone #_____

Emergency Contact_____ Emergency Contact Phone # _____

How did you hear about us? _____

Have you seen a chiropractor before? □ Yes □ No

Approximately how long were your visits? _____

Was that too long or not long enough? _____

For office use only

Height: _____ Weight: _____ Blood Pressure_____/_____ Pulse: _____

INJURY STATUS

Reason for today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic

Did your injury occur during: □ Sports/ Play □ Accident □ Routine/ Household activity □ Other _____

When did your condition/ accident occur? _____ **Where did your injury occur?** _____

Please explain what happened: _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

On a scale of one to ten how intense are your symptoms? Not intense ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

My condition is aggravated by:

□ Standing too long	□ Sitting too long	□ Driving	□ Sneezing	□ Coughing
□ Pulling	□ Laying on my back	□ Laying on my stomach	□ Bending	□ Bowel movement
□ Pushing	□ Twisting	□ Stooping	□ Vacuuming	□ Lifting over _____lbs.

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine? If so, how: _____

_____

CURRENT HEALTH CONDITION(S)

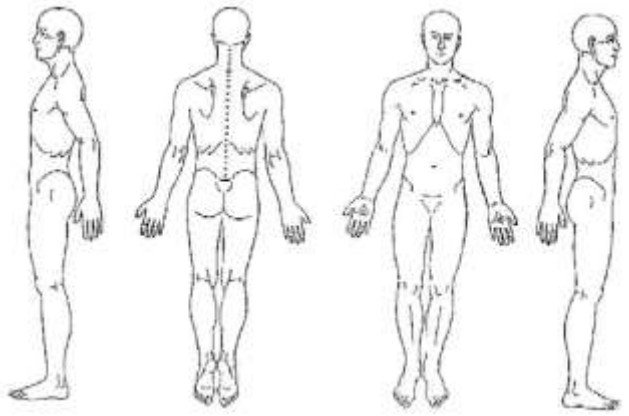
Using the adjacent body charts, please *circle* all affected areas. What are your current health condition(s)?

1. _____
2. _____
3. _____

Have you been treated by another physician for this/these condition(s)?

□ Yes □ No If so, please list other Doctors:

1. _____
2. _____
3. _____



LEFT **BACK** **FRONT** **RIGHT**

Medication Currently Taking:

Medication Name	Dosage & Frequency

Medication Allergies:

Medication Name	Reaction	Onset Date

List any surgeries or hospitalizations you have had complete with the month and year for each: _____

_____

Do you have or have you had any diseases, medical conditions or procedures? _____

_____

List any past serious accidents with dates: _____

_____

Family Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): _____

_____

Previous X-rays taken? □ Yes □ No Areas: _____

Do you exercise? □ Yes □ No Hours per week_____ What activity(s)? _____

Are you dieting? □ Yes □ No Since: _____

Do you drink alcoholic beverages? □ Yes □ No _____drinks per day

Do you use tobacco? □ Yes □ No _____packs per day. How many years have you been using tobacco? _____

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics □ No If so who recommended them? _____

For women:

Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? _____

Date of last menstrual period: _____

HIPPA PRIVACY

Prater View Chiropractic and Health Clinic
Darnell Simpson D.C.
Devin Simpson D.C.
118 S. Main St. Suite 400
Thayne, WY 83127

Phone: 307-883-7246
Fax: 307-883-7247

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessment and physical certifications.

I have received, read and understand your Notice and Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I choose to decline receipt of my clinical summary after every visit. At any time I can request these me emailed to me.

Patient Signature Date

Parent or Guardian Date

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Thayne, WY 83127
Phone: 307-883-7246

Financial Policy

Cost of Services

	TOS	Personal Insurance
➢ Initial history and exam consult:	$35.00	$80.00
➢ Treatment	$40.00	$65.00
➢ Modalities	$5.00	$35.00

- Ultrasound, E-Stim, Myofascial, Traction, Rehab Exercises

- All X-rays and supplies will be the same for cash, personal insurance and unsecured payment arrangements.
- All treatment for Workers Compensation or Personal Injury Claims will be billed out to individual companies as unsecured payment schedule. To see this schedule please ask billing department.

Payment:
If you have insurance and wish to bill your own insurance, we will supply you with a super bill to do so. (You will pay TOS prices) If you would like Prater View Chiropractic to bill your insurance, we will be happy to do so and you will pay insurance prices. We ask that you pay your co-pay, co-insurance and/or deductible at time of service. If payment is denied by your insurance company you will be responsible for the amount not covered and a statement will be mailed to you. Your account may be assessed interest and/or late fees after 30 days. I/We further agree to pay a finance charge of 18% annual interest rate of the unpaid balances, or a minimum of $1.50 per month.

Collections: All accounts over 90 days past due or not in good standing will be turned over to our collection agency. Monthly payments must be made to keep your account current. You will be responsible for any legal fees if legal action is taken.

Missed Appointments
We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, **or do not provide us with 24 hours notice**, you will be charged a $30.00 "broken appointment fee". Broken appointment fees must be paid prior to rescheduling your next appointment.

I have read the above statement and understand this office policy.

Patient Signature Date

Parent or Guardian if patient is a minor Date

Record Release and Assignment of Insurance Benefits

The undersigned hereby authorizes the Release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.
I (patient) _____ hereby authorize (Insurance Co.)_____ _____ to pay and hereby assign directly to Dr. Darnell Simpson and/or Dr. Devin Simpson all owed benefits. I understand I am financially responsible for all charges incurred.

Patient Signature Date

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	
ultrasound	hot/cold therapy	Electrical Stim
radiographic studies	mechanical traction	Massage/Myofascial Therapy

Physicals (DOT, Sports, other)

_____

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and possible X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT

I hereby request and authorize Dr. Devin Simpson and Dr. Darnell Simpson to perform diagnostic test and render chiropractic adjustment and other treatments to my minor son/daughter: _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above, (if applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Devin Simpson or Dr. Darnell Simpson* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature of Patient / and or Parent/Guardian **Signature**