Suchey CHIROPRACTIC PLLC

2026 Update

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____**Preferred Name**:_____

Address:_____**City**:_____**State:**_____**Zip:**_____

Birthdate:_____/_____/_____ **Age**_____ **Gender**: □ Male □ Female **SSN**:_____/_____/_____

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Home Email:_____ **Work Email**:_____

By providing my email address & cell phone, I authorize my doctor to contact me via email/text provided.

Emergency Contact: (Name, Relationship, Phone#)_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) and ID to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

Primary Insurance Carrier:_____ Phone:_____

Policy#_____ Group #_____ Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____ Employer:_____

Is patient covered by another insurance? □ Yes □ No **Secondary Insurance Carrier**:_____Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Suchey Chiropractic PPLC all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

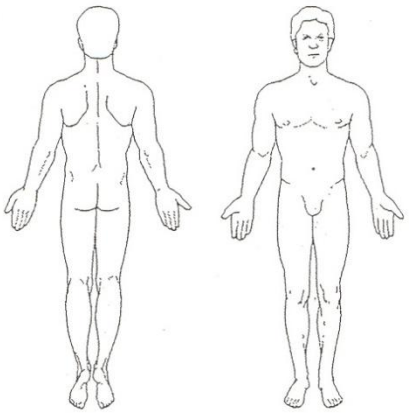
Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? **Circle all** that apply*: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

On the scale below, please circle the severity of your main complaint right now:

No Pain ***Moderate Pain*** ***Worst Possible Pain***

0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

Area for doctor's notes:

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know <u>allergies you have had to prescription medications</u>. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?:

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓:**

If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

NAME:_____ DATE:_____

INFORMED CONSENT

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

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. This 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 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
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain)_____

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 treatments. 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 X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include: 1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE <u>CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:</u>

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Suchey Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Suchey Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. 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:_____

_____

Patient's Name (Please print)

X_____

Signature of Patient, Parent or Legal Guardian (if a minor)

OFFICE INFORMATION

Permission to share your medical information.

I authorize the release of information to the following individuals listed in the spaces blow (Ex: spouse, children, other family members): Name/Relationship:_____

INSURANCE COVERAGE & PATIENT RESPONSIBILITY Your health insurance plan may have limitations or exclusions for services provided in our office. Depending on your individual plan, services that may not be covered include, but are not limited to: **Examinations • Re-examinations • X-rays • Diagnostic Testing • Massage Therapy • Vitamins & Supplements • Supports/Braces • Therapies/Modalities**, including electrical muscle stimulation (EMS), ultrasound, and hot/cold therapy. We may verify your insurance benefits as a **courtesy**; however, verification of benefits is **not a guarantee of coverage or payment**. Your insurance policy is a contract between you and your insurance company, and final coverage is determined by your insurance plan when the claim is processed. **All applicable payments, copayments, and patient-responsibility amounts are due at the time services are rendered.** By signing below, you acknowledge that you may be financially responsible for services that are denied, excluded, considered non-covered, or otherwise not paid by your insurance plan. As a courtesy, Suchey Chiropractic will submit claims to your health insurance when applicable. If a claim remains unpaid after 90 days, the outstanding balance may be transferred to the responsible party for payment. I understand that any X-rays taken by Suchey Chiropractic will remain the property of the office. Copies may be requested.

RE-EXAMINATIONS & ACTIVE PATIENT STATUS To help ensure your care remains appropriate and up to date, a **re-examination is required at least once per year**. If your insurance plan does not cover the re-examination, you understand that you are responsible for the charges associated with that visit. **To remain an active patient, you must be seen in our office at least once per year.** If it has been: **Less than 1 year** since your last visit — You are considered an active, established patient. **2+ years** since your last visit — A scheduled **re-examination appointment** is required. Please allow **30+ minutes** for this appointment. **3+ years** since your last visit — You will no longer be considered an established patient and will need to schedule as a **new patient**. Please allow **45+ minutes** for this appointment.

SAME-DAY APPOINTMENTS & WALK-INS We are happy to offer same-day appointments when our schedule allows. To qualify for a same-day appointment, you must be an **established patient who has been seen in our office within the past year**. **Dr. Hunter Traver also welcomes walk-in patients during his regular office hours.** Walk-in and same-day availability is based on the provider's schedule and **cannot be guaranteed**. Scheduled patients will be given priority. If you have not been seen within the required timeframe, a re-examination or new patient appointment may need to be scheduled before treatment can be provided.

NOTICE OF PRIVACY By signing below, I acknowledge that I have been provided the opportunity to review Suchey Chiropractic's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed for purposes including treatment, payment, and healthcare operations. A copy of the Notice of Privacy Practices is available upon request. Please ask a member of our staff if you would like a copy.

CLINICAL SUMMARY I understand that I may request a clinical summary or other information regarding my care. Due to the nature and frequency of chiropractic treatment, visit summaries may contain repetitive information. By signing below, I acknowledge that I do not require a clinical summary to be provided to me automatically after each visit. I may request a clinical summary at any time by asking a member of our staff.

Dated:_____

_____

Patient's Name (Please print)

X_____

Signature of Patient, Parent or Legal Guardian (if a minor)