Sheridan Chiropractic, Inc.

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CONFIDENTIAL PATIENT REGISTRATION & HISTORY

PATIENT INFORMATION:

Today's Date: _____ How did you hear about us? _____

Name: _____

DOB (Month/Day/Year): ____/____/_____ Age: _____ Gender: M // F SS#: _____-____-_____

Home Address: _____ City: _____ Zip Code: _____

Cell #: _____ Home #: _____ Work #: _____

Email Address: _____

EMPLOYER NAME: _____ Occupation: _____

Address: _____ City: _____ Zip Code: _____

Phone #: _____ Fax: _____ # Hours/Week Worked: _____

EMERGENCY CONTACT: _____ Relation: _____ Phone #: _____

HEALTH INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Policy Holder Name: _____ Policy #: _____

Relationship to Policy Holder: _____ Group #: _____

PRIMARY PHYSICIAN INFORMATION:

Physician Name: _____ Phone #: _____

Address: _____

CURRENT COMPLAINTS

What are your current complaints? _____

When did your symptoms first appear? _____

Do your symptoms interfere with: ☐ Sleep ☐ Daily Routine ☐ Work ☐ Recreation

Are you working less hours/days as a result of your complaints? ☐ Yes ☐ No

If yes, please explain: _____

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

How would you rate your symptoms:

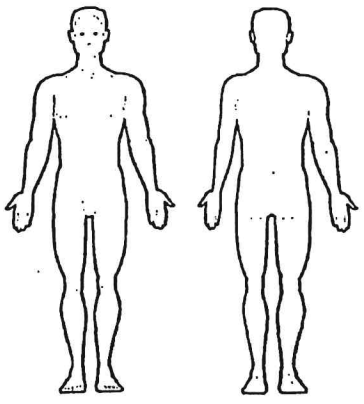
☐ Mild ☐ Moderate ☐ Severe

How would you rate your current pain level?

No pain	Minimal			Slight			Moderate			Severe Pain
0	1	2	3	4	5	6	7	8	9	10

Are your symptoms: ☐ Improving ☐ Unchanged ☐ Worsening

Mark with an "X" on the areas of your pain on the diagram to the right.



HOSPITALIZATION / EXAMINATION HISTORY:

Have you been to the hospital for *this* condition? ☐ Yes ☐ No When did you go? _____

Name of the hospital: _____ How did you get there? ☐ Self ☐ Others ☐ Ambulance

Were x-rays taken? ☐ Yes ☐ No If yes, what areas? _____

Were you prescribed medication? ☐ Yes ☐ No What medication? _____

Have you seen any other doctor or received any other treatment for your current condition? ☐ Yes ☐ No

If yes, explain: _____

Doctor's name & address: _____

Phone #: _____ Date seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (Place "X" in boxes that apply)

Test	Region/Body Parts	Date	Test	Region/Body Parts	Date
☐ Examination	_____	_____	☐ EMG/NVG	_____	_____
☐ MRI/CT	_____	_____	☐ _____	_____	_____

HEALTH HISTORY/INJURIES/TREATMENTS:

INJURIES YOU MAY HAVE HAD IN THE PAST **DATES**

Auto Accidents: _____ _____

Work Injuries: _____ _____

Broken Bones: _____ _____

Other: _____ _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERED FROM:

☐ Muscle Disorder	☐ Asthma	☐ Osteoarthritis	☐ Coughing Blood
☐ Nervous System Disorder	☐ Broken Bones	☐ Epilepsy	☐ Circulatory Problems
☐ Bone Disorder	☐ Intestinal Problems	☐ Alcoholism	☐ Kidney/Bladder Problems
☐ Rheumatoid Arthritis	☐ Seizures/Convulsions	☐ Drug Addiction	☐ Heart Disease
☐ Allergies	☐ Congenital Disease	☐ Strokes	☐ Tumors
☐ HIV	☐ Excessive Bleeding	☐ Cancer	☐ Depression
☐ Gallbladder Issues	☐ High Blood Pressure	☐ Ulcer	☐ Ear/Throat Infection
☐ Diabetes	☐ Low Blood Pressure	☐ Hernias	☐ Pacemaker

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION: **DATE(S)**

Spine Surgeries: ☐ Discectomy ☐ Laminectomy ☐ Fusion ☐ Other: _____ _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION:

☐ Medication ☐ Injections ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Acupuncture

☐ Other: _____

Medication(s) Currently Being Taken: _____

Female Patients: Most recent menstrual cycle: _____ ☐ Pregnant: _____ weeks

AUTHORIZATION FOR TREATMENT

I hereby authorize Sheridan Chiropractic to treat my condition as they need appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to SCI for x-rays is for examination only and the x-ray negatives will remain property of SCI. They will be kept on file where they may be seen anytime while I am treating at SCI. I am responsible for all bills incurred at this office. I will not hold SCI responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I agree that the statements made in this questionnaire are true and correct.

Patient's Signature: _____ Date: _____

Informed Consent Document

PATIENT NAME: _____

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 used by doctors 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 I 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 testing _____cold therapy _____EMS
_____radiographic studies
_____Other (please explain)

_____

_____

(Patient should initial each procedure they are consenting to.)

The 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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and 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 (MINOR)

I hereby. request and authorize (insert your name) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____.This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

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 [ ] I or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (insert your name) 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 or the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

HOW WE PROTECT YOUR PRIVATE HEALTH INFORMATION

My "protected health information" (PHI), means personal health information, including my demographic information, collected from me and/or created or received by my physician, medical assistant or other heathcare provider. PHI may relate to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my PHI by Sheridan Chiropractic, Inc. or any owner, employee, contractor or other representative therof (collectively, "Provider), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct heath care operations of Provider. I understand that Provider may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my PHI for the above-stated purposes. My signature on this document establishes my consent to the use or disclosure of my PHI for the above-stated purposes.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations by Provider. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding upon Provider.

I understand I have a right to review this office's Notice of Privacy Practices prior to signing this document. Provider's Notice of Privacy has been provided to me. Provider's Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occour in my treatment, payment of my bills or in the performance of health care operations by Provider's office. Notice of Privacy Practices also describe my rights and Provider's duties with respect to my PHI.

I acknowledge and understand that Provider has the right to change the privacy practices described in Provider's Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting Provider's Privacy Officer at dd.sheridanchiro@gmail.com, to request a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Provider has taken action in reliance on this agreement.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding Provider's Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name _____

Patient Signature _____ Date _____

Witness Printed Name _____

Witness Signature _____ Date _____

Financial Policy Summary

Sheridan Chiropractic, INC.

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or prompt payment option.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of _____ our office will be unable to extend any type of discounts other than those listed above.

Acknowledged by: _____ Date: _____