Acadia Chiropractic
NLMDC PLLC
10050 W Bell Road Ste. 14
Sun City, AZ 85351
623-972-0262
Dr. Nathan Moon DC

Informed Consent for Chiropractic Care &/or Acupuncture

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, Acupuncture, manual electric stimulation (Electro-Acupuncture) on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future work at NLMDC, PLLC.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine. In the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Print _____ Date _____

Patient Signature_____Date_____

Witness Signature_____ Date_____

Doctor Signature _____ Date_____

Patient Information

How were you Referred to Us? _____

Name: _____ **E-Mail Address:** _____

Home Phone: _____ **Cell Phone:** _____ **Reminder Text: Yes:** _____ **No:** _____

Permanent Street Address: _____ **City, State, Zip** _____

Social Security Number: _____ **Date of Birth:** _____

Emergency Contact: _____ **Phone Number:** _____

Authorization & Assignment Policy

To: NLMDC PLLC dba Acadia Chiropractic

It is my understanding that if I become a patient in this office, I agree to the following: I understand and agree that Health and accident policies are an arrangement between an insurance carrier and myself. I also understand that there is a possibility of denial of coverage by my insurance carrier, including Medicare, for services rendered in this office. Furthermore, I understand that **NLMDC PLLC dba Acadia Chiropractic** will prepare any necessary reports and forms to assist me in making a collection from the insurance company, and any amount authorized to be paid directly to **NLMDC PLLC dba Acadia Chiropractic** will be credited to my account upon being received. Additionally, I understand that my insurance requires this provider to collect co-payments and deductibles.

Authorization to Release Information:

I am authorizing you to release any information you feel appropriate concerning my condition to any insurance company, attorney or adjuster in order to receive reimbursement on any charges incurred.

Authorization to Pay Directly to Doctor:

I authorize the direct payment to you of any sum I now or hereafter owe you from any insurance company that is obligated to reimburse me for charges incurred in your office in part or in full or my attorney out of the proceeds of my settlement. I give limited power of attorney to you for endorsement of any check issued in my name (the patient) and/or jointly to the patient and provider by any party billed for services rendered. A photocopy of this form is acceptable for payment.

Assignment of Cause of Action:

I hereby assign and give to you the right to take action against any insurance company that is obligated by contract to make payment to me, including filing complaints with the Insurance Commissioner. It is understood that all reasonable efforts will be made to collect from the insurance company before you will pay that amount to collect amount owed directly from. **Also understand that should I receive the insurance check; I will pay that amount to your office within 5 days of receiving or be responsible for the entire amount billed.**

For Personal Injury Cases:

I understand that in the event that there is no valid coverage, I will be responsible for all the charges incurred. Overdue accounts are subject to 1.8% interest per month. This Authorization and Assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.

Patient Signature: _____ Date: _____

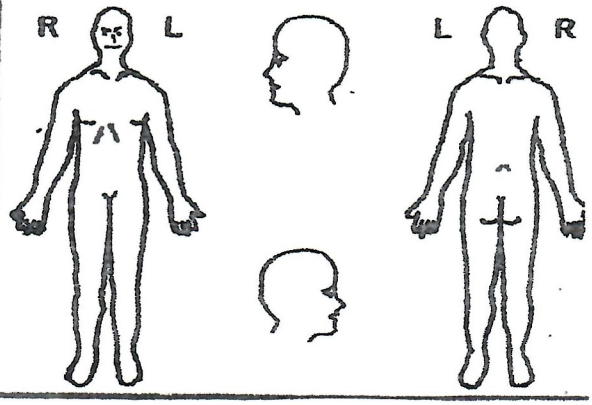
NLMDC, PLLC
623-972-0262
HISTORY-CURRENT ILLNESS/PAIN

Patient Name:_____ Date:_____
For Established Patients Only: are there any changes to your current history on file? ____NO____Yes

Where is your pain and/or other symptoms located?
Please mark the areas of complaint on the diagram to the right.
Describe your pain / symptoms.....
Use the abbreviations below to indicate which type of pain/symptoms you are experiencing. If your pain/symptoms "moves" use arrows on the diagram to show the direction.

B = burning	A = aching
ST = stiff	S = sharp
D = dull	N = numbness
T = tingling	P = pins & needles
TH = throbbing	R = radiating

Mark your area of pain on the figure below



Are your symptoms constant?_____ Do your symptoms come and go?_____
How long have you had this problem?_____
How did your symptoms start?_____
_____

Average Pain Intensity:
(Please Circle) No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
How long does your pain last?_____ What makes it Better?_____
What makes it worse?_____
Do any of the following affect your pain/discomfort or make it worse? Y / N
_____Standing _____Sitting _____Coughing / sneezing _____Activity _____Do you have trouble sleeping
How do you feel upon arising in the morning?_____
What other treatments have been rendered or have you tried for this/these problem(s)?_____
_____

Patient Signature:_____ Date:_____

---------- Section Below to be Completed by the Doctor ----------

Patient Type
___ New to this office
___ Est'd, new injury
___ Est'd, new episode

Cause of Current Episode
___ Traumatic ___ Recurrent/repetitive
___ Unspecified ___ Post surgical – Date/type_____

Doctor Signature_____ Date this submission to begin_____

Dr. Nathan Moon DC

Functional Rating Index

In Order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities

Your Primary Complaint Today:

☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

For Each item Below, Please circle the number which most closely describes our condition Right Now

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Distrubed	Moderately Distrubed	Greatly Disturbed	Totally Distrubed

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain: No Restrictions	Mild Pain: No Restrictions	Moderate Pain: need to go slowly	Moderate Pain; need some	Severe Pain; need 100% assistance

4. Traveling (Driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain; on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus extra	Can do usual; no extra	Can do 50% of usual work	Can do 25% of usual work	Can Not Work

6. Recreation

0	1	2	3	4
Can do all Activies	Can do most Activites	Can do some Activities	Can do few Activites	Cannot do Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional 25% of the	Intermittent 50% of the	Frequent 75% of the	Constant 100% of the

8. Lifting

0	1	2	3	4
No Pain	Increased Pain	Increased Pain	Increased Pain	Increased Pain

9. Walking

0	1	2	3	4
No Pain; any distance	Increased pain; after 1 mile	Increased pain; after 1/2 mile	Increased pain; after 1/4 mile	Increased pain; w/all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hor	Increased pain after 1/2 hour	Increased pain w/any standing

Name: _____
Printed

Total Score: _____

_____
Signature

Date: _____

Patient History

Patient Name: _____ Date: _____

Have you have any serious injuries: Y/N _____ If Yes, please describe _____

_____

Have you had any of the following operations? If yes please give date

Appendectomy _____ Hernia _____ Hysterectomy _____ Tonsillectomy _____

Gallbladder _____ Back _____ Neck _____ Shoulder _____ Knee(s) _____

Shoulder(s) _____ Cataract _____ Prostate _____ Other (please List) _____

_____

Have you ever had any of the following or any other serious illness? If yes, please give date

Arthritis _____ Asthma _____ Blood Disease _____ Diabetes _____

Digestive Prob _____ Dizziness _____ Heart Disease _____ Hepatitis _____

High B.P. _____ Kidney Disease _____ Liver Disease _____ Pneumonia _____

Rheumatic Fever _____ Scarlet Fever _____ Thyroid Disease _____ TB _____ Ulcer _____

Other _____

Are you ever bothered with . . . .

_____Vision Problems
_____Nervousness/Depression
_____Chronic Cough
_____Trouble with Ears
_____Frequent Headaches
_____Abnormal bleeding/discharge
_____Digestive Disorders
_____Fainting Spells
_____Blood in stools
_____Trouble Urinating
_____Losing urine while coughing/sneezing
_____Shortness of Breath
_____Chest Pain
_____Frequent Dizziness
_____Sinus Trouble

Do you . . . .

_____Wear contacts/glasses
_____Have metal implants
Have any false teeth
Have a joint replacement/which joint? _____
Have a pacemaker
_____Drink caffeine? If yes, list # of cups and type _____
_____Drink Alcohol? If yes, list # of glasses and type _____
_____Have any allergies? If yes, please list _____
_____Smoke? If yes, what do you smoke (cigarettes, cigars, pipes) _____
Packs per day _____ or amount _____

Family History

Are any of the following in your family . . . .

_____Asthma
_____Heart attacks
_____Strokes
_____Cancer
_____Heart Disease
_____Tuberculosis
_____Diabetes
_____High Blood Pressure
_____Kidney Disease
_____Glaucoma
_____Rheumatoid Arthritis

Medications

Medication **Reason for Medication**

_____

_____

_____

_____

_____

_____

Patient Signature **Date**