About the Patient

Name _____

Date of Birth (month/day/year) _____/_____/_____ Age_____ Gender: M / F

Marital Status: ○ Married ○ Life Partners ○ Single ○ Divorced ○ Widowed

Address_____

City_____ State_____ Zip_____

Primary Phone (_____)_____-_____ Secondary/Work Phone (_____)_____-_____

Type of Work/Student _____Employer/School_____

Email:_____@_____._____

Referred by:_____

About the Spouse or Parent

Name_____

Address_____

City_____ State_____ Zip_____

Phone Number (_____)_____-_____

Relationship_____

Emergency Contact

Name_____

Address_____

City_____ State_____ Zip_____

Phone Number (_____)_____-_____

Relationship_____

Experience With Chiropractic

Have you been adjusted by a chiropractor before? (circle one) Yes No

Reason For Visit?_____

Doctor's Name_____ Approximate Date of Last Visit_____

Chief Complaints

Where is your injury/pain located?_____

Intensity of pain (circle 1 being least, 10 being worst) 1 2 3 4 5 6 7 8 9 10

Onset of this episode? (day/month/year) _____/_____/_____

Frequency of pain? (circle one) 0%-25% 25%-50% 50%-75% 75%-100% Of the (circle one) Day Week Month

When does it hurt the most? (circle one) Morning Afternoon Evening Night

Does the pain shift or radiate from original location?_____

What is the quality of pain? (Check each box that applies)

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	Stiffness

What are the aggravating factors? (Check each box that applies)

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking up	Looking down	Movement	Rest	Lying supine	Driving
Typing	Scooping	House chores	Exercise	Lying prone	Stair stepping

What, if anything , relieves some of the pain? (Check each box that applies)

Sitting	Standing	Lying	Knees bent up	Support
No movement	Movement	Heat	Ice	Analgesic topical
Ibuprofen	Medication	Rest	Stretching/exercise	Adjustments

Credit Card Information

In our office services are frequently rendered in anticipation of payment from a health reimbursement account or an insurance company. Any time services are rendered without immediate payment credit is extended. We ask you to guarantee that credit with a personal credit card. Please be assured your card will NEVER be charged without your prior notification.

Please initial each paragraph after you have read it. Thank you.

_____In the event that my insurance company refuses payment to CT Chiropractic for any reason, I will become personally responsible for that amount. I will have 30 days (once notified by CT Chiropractic) to take care of the outstanding balance by calling my insurance company. If the account is not cleared within 30 days, I am responsible to pay the balance due. I hereby authorize CT Chiropractic to collect any outstanding balance from my credit card (listed below), if I fail to pay the balance due within 30 days.

_____ I will promptly bring any insurance checks that I receive to the office of CT Chiropractic. If I fail to do so within 1 week of receiving it, I understand that my credit card (listed below) may be charged for the amount owed.

_____If my insurance company fails to pay any portion of my bill, and I do not make payment within 30 days of being notified by CT Chiropractic, I give my permission for CT Chiropractic to charge the credit card (listed below) for the balance due.

_____Any balance on my account will be paid for and cleared within 30 days of notification of the amount. If a balance remains past 30 days, I hereby authorize CT Chiropractic to collect the amount in full by charging the credit card listed below.

The signed credit card is only to be used for services rendered at CT Chiropractic.
The doctor agrees not to add any charges directly to my account
for services that were not performed or products not purchased.

Patient Name:_____

Address:_____City:_____State:_____Zip:_____

Credit Card: Visa_____ MasterCard_____

Credit Card Number:_____

Expiration:_____ CVV:_____ Billing Zip_____

Patient Signature:_____ Date:_____

Witness Signature:_____Date:_____

Terms of Acceptance

_____ When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method of chiropractic care in order to attain results. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during your course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____It is the practice of this office to provide chiropractic care in an "OPEN ADJUSTING" environment. Some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

Authorization for Care

_____I Authorize the Doctor, Kelli Dodge D.C., to work with my condition through the use of adjustments to my spine, as she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

Health Insurance Coverage

_____I clearly understand that my health insurance is a contract between me and my health insurance company. I understand that this office is providing me with complimentary service by billing my insurance company for me. I agree that any services rendered that are not covered by my insurance policy are solely my financial responsibility.

I, _____ have read, and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office (CT Chiropractic & Wellness Center) have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Sign: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES DISCLOSURE

CT Family Chiropractic, LLC

Please read and understand the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY following this disclosure.

Please indicate with whom we can discuss health information, appointment scheduling and/or billing.

Spouse:_____ ☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Parent/s or Guardian/s: _____ Indicate Relationship: _____

☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Relative/Friend/Other: _____ Indicate Relationship: _____

☐ Yes, Health ☐ Yes, Billing ☐ Yes, Scheduling

Acknowledgment of Receipt of this Notice As a patient of CT Family Chiropractic, I acknowledge that I have read the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY and understand that I may request a copy of the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY for detailed information. I understand that CT Family Chiropractic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree with all conditions stated in the HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY.

Printed Name: _____

Signature of Patient: _____ Date: _____/_____/_____

(Parent or Guardian Signature if Patient is a Minor)