QUICK FIX
AFTER HOURS Chiropractic Care

INFORMED CONSENT

The care by the doctors at Quick Fix, LLC is reimbursed by the patient at the time of service. A "Superbill" receipt is provided, which is the universal form used by insurance companies for reimbursement directly to the patient. It is the responsibility of the patient to know the details of his/her insurance policy and submit this form if seeking insurance reimbursement.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, which may include various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors of chiropractic who now or in the future work at Quick Fix After Hours Chiropractic Care, LLC.
I have had an opportunity to discuss with the doctors and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as with the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, 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 or 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. I understand and agree that there is no guarantee that my health insurance will reimburse me for the care that I am receiving. The doctor whose help I am requesting will recommend what he/she believes to be in my best interests and takes great care in making these services affordable so that no one is denied access to better health. If financial burdens are preventing compliance with the doctor's recommendations, I will privately discuss options with her/him so that economic considerations are not a deterrent to my healing.

Patient Signature__________________________________

Date_________________

QUICK FIX
AFTER HOURS Chiropractic Care

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

Confidential Health Information

1. Patient Contact

		Clinic ID	Date
Last Name	First Name		M.I.
Age	Date of Birth	Social Security	Sex ○ male ○ female
Street	City	State	Zip
Home Phone	Mobile Phone		
Work Phone	Email		
Who referred you to our office?			

2. Patient Personal

Occupation	Employer
Employer Address	

Status ○ single ○ married ○ partnered ○ widowed ○ separated ○ divorced

Race (check one) ○ White ○ Black/African-American ○ Asian ○ American Indian ○ other_________ ○ declined to state

Ethnicity (check one) ○ Non-Hispanic ○ Hispanic or Latino ○ declined to state

Preferred Language

Smoking Status (check one) ○ never smoked ○ daily ○ weekly ○ monthly ○ yearly ○ former smoker

Do you have any allergies to medications? ○ yes ○ no

List allergy reaction start and end date:

List any prescription or over-the-counter medicines you are currently taking, and the doses.

	Medication	Reason	Dose
1.			
2.			
3.			

3. Emergency Contact

Name	Home Phone
Relationship	Work Phone

4. Spouse or Guardian

Last Name	First Name	M.I.
Best Contact Number	Date of Birth	

5. Health Complaints

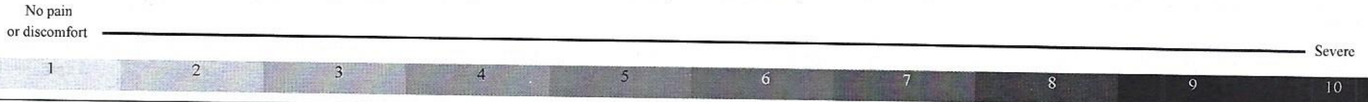
What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does this **primary** complaint feel? ○ dull/achy ○ sharp ○ numb ○ tingling ○ burning ○ cold How often do you experience the **primary** complaint? ○ constantly ○ daily ○ weekly ○ monthly ○ yearly

Using the scale below, rate how your **primary** complaint affects your life (mark only one box below).

No pain or discomfort — Severe



Does this pain radiate? ○ no ○ yes, to what location?

What makes your problem worse? ____________________

What makes your problem better? ____________________

If you have missed work because of your **primary** complaint, when was your last day of work?

List any tests, studies, or medications received for this condition:

Were you admitted to the hospital due to this condition? ○ yes ○ no Do you have any other condition other than what brings you here? ○ yes ○ no

If **YES**, list here:

If due to an accident, injury, or illness, please describe:

Doctor's remarks:

6. Lifestyle & Habits

What are your exercise activities? (mark all that apply) ○ I don't exercise

○ walking ○ swimming ○ weight lifting ○ stretching/flexibility ○ yoga/pilates ○ resistance bands

○ running/treadmill/rowing/climbing ○ group exercise classes ○ Other____________________

List any nutritional supplements you are currently taking.

____

7. Family History

List any conditions as they pertain to your family history:

Mother ____________________ Brother____________________

Father ____________________ Sister ____________________

8. Conditions

Mark any conditions that pertain to you.

appendicitis	○ yes ○ no	low back pain	○ yes ○ no	scoliosis	○ yes ○ no
arthritis	○ yes ○ no	mental disorder	○ yes ○ no	stroke	○ yes ○ no
cancer	○ yes ○ no	multiplesclerosis	○ yes ○ no	thyroid disorder	○ yes ○ no
epilepsy	○ yes ○ no	neck pain	○ yes ○ no		
heart disease	○ yes ○ no	post-polo	○ yes ○ no		

9. Injuries

List any injuries, car accidents, etc., and dates:

____

____

____

10. Hospital/Medicine

What types of surgeries have you had?

Do you have any other implantable medical devices in your body? ○ yes ○ no

List any broken bones or dislocations that you have had.

Have you ever been to a chiropractor before? ○ yes ○ no Approximate date of last adjustment:

Date of last physical examination:

11. System Review

Mark the following conditions that are **currently** a cause of significant concern for you.

General

○ consistent fainting
○ loss of weight
○ weight gain
○ chills
○ fatigue
○ neuralgia
○ depression
○ fever
○ night sweats
○ dizziness
○ headache
○ wheezing
○ loss of sleep
○ nervousness

Gastro-Intestinal

○ constipation
○ liver problems
○ rectal bleeding
○ diarrhea
○ nausea
○ vomiting
○ gall bladder problems
○ stomach pain
○ vomiting blood
○ hemorrhoids
○ poor appetite
○ jaundice
○ poor digestion

Eye/Ear/Nose/Throat

○ asthma
○ ear noises
○ nasal obstruction
○ sore throat
○ crossed eyes
○ enlarged thyroid
○ nose bleeds
○ tonsillitis
○ deafness
○ frequent colds
○ pain in eyes
○ earache
○ hay fever
○ poor vision
○ ear discharge
○ hoarseness
○ sinusitis

Respiratory

○ chest pain
○ chronic cough
○ difficulty breathing
○ spitting blood
○ spitting phlegm

Muscles/Joints/Bones

○ backache
○ spinal curvature (scoliosis)
○ foot problems
○ swollen joints
○ pain between shoulders
○ tremors
○ painful tailbone
○ twitching
○ stiff neck
○ weakness

Cardio-Vascular

○ ankle swelling
○ poor circulation
○ high blood pressure
○ rapid heart
○ low blood pressure
○ slow heart
○ heart trouble
○ strokes
○ pain over heart

Skin or Allergies

○ bruise easily
○ sensitive skin
○ dryness
○ eczema
○ hives
○ itching

Women

○ cramps
○ excessive flow
○ hot flashes
○ irregular cycles
○ painful periods

QUICK FIX
AFTER HOURS Chiropractic Care

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can access this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- treat you
- discuss your case with family
- collect payment
- do research
- run our office
- include you in care classes
- inform you about other services
- thank you for referring other patients

We may use your health information to:

- health and safety reasons
- reporting to workers' compensation
- reporting to law officials
- reporting victims of abuse
- court hearings and filings

You have the right to:

- request a copy of your health record
- request confidential communications
- ask us to limit the information we share
- request a list of whom we share your health information with
- amend your protected health information
- advise our management if you believe your privacy rights have been violated

These privacy practices are effective: September 23, 2013
This notice will expire seven years after the date in which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform and procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short- and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care.
- I will be informed of fees and charged before the associated procedure or service is performed.
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered.
- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

____
Patient or Guardian Signature

____
Date