ADULT (18 - 64 YEARS)

TODAY'S DATE:____/____/____

PATIENT INFORMATION:

FULL NAME:____ DATE OF BIRTH:___/___/___ AGE:____

GENDER: ☐M ☐F HOME PHONE:_____________________ MOBILE PHONE:_________________________

ADDRESS:____

STREET ADDRESS CITY STATE ZIP + 4

E-MAIL ADDRESS:____

REFERRED BY: ☐ PHYSICIAN________________________ ☐ FAMILY/FRIEND__________________________

☐ TV COMMERCIAL ☐ PHONE BOOK ☐ OTHER______________________________

INSURANCE INFORMATION:

PLEASE PRESENT CURRENT INSURANCE CARD

COMPANY NAME:____ EFFECTIVE DATE:_____/_____/_____

INSURED'S NAME:___________________________________ INSURED'S DATE OF BIRTH:____/____/_____

☐ CURRENTLY UNINSURED, AND WILL BE PAYING OUT OF POCKET FOR SERVICES PROVIDED

ASSIGNMENT OF BENEFITS / INFORMATION RELEASE:

I AUTHORIZE AND DIRECT THAT PAYMENT BE MADE DIRECTLY TO A L WAGNER FAMILY CHIROPRACTIC FOR ANY AND ALL INSURANCE BENEFITS OR REIMBURSEMENT FOR SERVICES RENDERED BY THE PROVIDER, WHICH AMOUNTS WOULD OTHERWISE BE PAYABLE TO ME UNDER ANY INSURANCE OR PRE-PAID HEALTHCARE PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH AND HEALTHCARE SERVICES TO ANY INSURANCE COMPANY, ADJUSTER, PRE-PAID HEALTH PLAN, DOCTOR OR ATTORNEY INVOLVED IN THIS CASE. I UNDERSTAND THAT THERE IS NO GUARANTEE THAT MY INSURANCE COMPANIES OR PRE-PAID HEALTHCARE PLAN WILL COVER OR PAY FOR ALL OF MY CHARGES. NOTWITHSTANDING DENIAL, REDUCTION OF BENEFITS OR FAILURE TO PAY FOR ANY REASON, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL REMAINING CHARGES.

SIGNATURE:____ DATE:______________

WITNESS SIGNATURE:____ DATE:______________

CURRENT CONCERNS:

REASON(S) FOR SEEKING TREATMENT:____

____

HISTORY OF INJURY TO THE AREA? ☐Y ☐N

IF YES, PLEASE EXPLAIN:____

DATE OF INJURY/ONSET OF SYMPTOMS:_____/_____/______

CURRENT PAIN LEVEL: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE)

DESCRIPTION OF PAIN: ☐ACHING ☐SHARP ☐BURNING ☐NUMBNESS ☐TINGLING

SELF-CARE: ☐ICE ☐HEAT ☐OTHER____

OTHER HEALTHCARE PROVIDERS SEEN FOR THIS CONCERN: ☐Y ☐N

IF YES, NAME OF PRACTITIONER ______________ APPROXIMATE DATE OF TREATMENT___/___/____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? ☐Y ☐N IF YES, APPROX DATE___/___/___

ARE YOU PREGNANT ☐Y ☐N IF YES, DUE DATE ___/___/____ OB PHYSICIAN___________________

GENERAL HEALTH HISTORY:

CURRENT HEIGHT:_________ CURRENT WEIGHT:_______

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH HISTORY...

☐CONGENITAL HEART DEFECT ☐CANCER ☐DIABETES

☐KIDNEY PROBLEMS ☐SCOLIOSIS ☐ASTHMA

☐NECK PAIN ☐BACK PAIN ☐HEADACHES

☐ARTHRITIS ☐HIGH BLOOD PRESSURE ☐ARTIFICIAL JOINTS

☐CONSTIPATION ☐DIARRHEA ☐DIGESTIVE PROBLEMS

☐SLEEPING PROBLEMS ☐MENSTRUAL PROBLEMS (FEMALES)

☐OTHER CONDITIONS____

☐ALLERGIES/SENSITIVITIES____

☐MEDICATIONS____

☐VITAMINS/SUPPLEMENTS____

☐ACCIDENTS/INJURIES____

____

PRIMARY CARE PHYSICIAN____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: ____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.
WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING: ASHLEY L. WAGNER TELEPHONE: 701.557.7455

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE
I, ___________________________________(PRINT), HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE:____DATE: _________________________
RELATIONSHIP TO PATIENT (IF APPLICABLE): ____
AUTHORIZED PROVIDER REPRESENTATIVE SIGNATURE:____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

THERE ARE RISKS AND POSSIBLE RISKS ASSICIATED WITH CHIROPRACTIC MANIPULATIVE TREATMENT USED BY DOCTORS OF CHIROPRACTIC. IN PARTICULAR YOU SHOULD NOTE:

1. WHILE RARE, SOME PATIENTS MAY EXPERIENCE SHORT TERM AGGRAVATIN OF SYMPTOMS, OR MUSCLE AND LIGAMENT STRAINS OR SPRAINS AS A RESULT OF CHIROPRACTIC MANIPULATIVE TREATMENT TECHNIQUES. ALTHOUGH UNCOMMON, RIB FRACTURES HAVE ALSO BEEN KNOWN TO OCCUR FOLLOWING CERTAIN CHIROPRACTIC PROCEDURES;
2. THERE ARE REPORTED CASES OF STROKE ASSOCIATED WITH VISITS TO MEDICAL DOCTORS AND CHIROPRACTORS. RESEARCH AND SCIENTIFIC EVIDENCE DOES NOT ESTABLISH A CAUSE AND EFFECT RELATIONSHIP BETWEEN CHIROPRACTIC TREATMENT AND THE OCCURRENCE OF STROKE. STUDIES SUGGEST THAT PATIENTS MAY BE CONSULTING MEDICAL DOCTORS AND CHIROPRACTORS WHEN THEY ARE IN THE EARLY STAGES OF A STROKE. IN ESSENCE, THERE IS A STROKE ALREADY IN PROGRESS. HOWEVER, YOU ARE BING INFORMED OF THIS REPORTED ASSOCIATION BECAUSE A STROKE MAY CAUSE SERIOUS NEUROLOGICAL IMPAIRMENT, OR EVEN DEATH. THE POSSIBILITY OF SUCH INJURIES OCCURRING IN ASSOCIATION WITH A CERVICAL ADJUSTMENT IS EXTREMELY REMOTE;
3. THERE ARE RARE REPORTED CASES OF DISC INJURIES IDENTIFIED FOLLOWING CERIVAL AND LUMBAR SPINAL ADJUSTMENT, ALTHOUGH NO SCIENTIFIC EVIDENCE HAS DEMONSTRATED SUCH INJURIES ARE CAUSES, OR MAY BE CAUSED BY SPINAL ADJUSTMENTS OR OTHER CHIROPRACTIC TREATMENT;
4. THERE ARE INFREQUENT REPORTED CASES OF BURN OR SKIN IRRITATION IN ASSOCIATION WITH THE USE OF SOME TYPES OF ELECTRICAL THERAPY OFFERED BY SOME DOCTORS OF CHIROPRACTIC.

I ACKNOWLEDGE I HAVE READ THIS CONSENT AND I HAVE DISCUSSED, OR HAVE BEEN OFFERED THE OPPROTUNITY TO DISCUSS WITH MY CHIROPRACTOR THE NATURE AND PURPOSE OF CHIROPRACTIC TREATMENT IN GENERAL, AND THE CONTENTS OF THIS CONSENT.

I CONSENT TO THE CHRIROPRACTIC TREAMTENT RECOMMENDED TO ME BY MY CHIROPRACTOR, INCLUDING ANY RECOMMENDED SPINAL ADJUSTMENTS. I INTEND THIS CONSENT TO APPLY TO MY PRESENT AND FUTURE CHIROPRACTIC CARE.

PATIENT/LEGAL GUARDIAN NAME (PRINT):____

PATIENT/LEGAL GUARDIAN SIGNATURE:_____________________________ DATE:____________

PROVIDER ACKNOWLEDGEMENT OF CONSENT:____