

**Gillis Chiropractic Clinic  
PERSONAL HISTORY**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height/Weight: \_\_\_\_\_

Name of your Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_ Are you covered by this insurance?: \_\_\_\_\_

Name and Phone Number of Nearest Relative (Outside of your Home): \_\_\_\_\_

Who is responsible for your bill? (circle): Insurance Workman's Compensation Medicaid Medicare Self  
Auto Insurance Other: \_\_\_\_\_

Referred by (circle): TV Yellow Pages Previous Patient Internet Facebook

Friend: \_\_\_\_\_ Other: \_\_\_\_\_

**PAST HEALTH HISTORY**

**SURGERIES:** (Spinal or joint) \_\_\_\_\_

**ACCIDENTS OR FALLS:** (Please Describe) \_\_\_\_\_

**FRACTURES OR DISLOCATIONS:** \_\_\_\_\_

**HABITS:** Sleep (hours): \_\_\_\_\_ Coffee: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Exercise: \_\_\_\_\_  
Tea: \_\_\_\_\_ Tobacco: \_\_\_\_\_

Are you taking any medications? (Please explain for what): \_\_\_\_\_

Are you Pregnant (circle): Yes No If yes, how far along: \_\_\_\_\_ Pacemaker (circle): Yes No

**AUTHORIZATION**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Gillis Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

WHEN DID SYMPTOMS APPEAR? \_\_\_\_\_

WAS THIS WORK OR AUTO RELATED? \_\_\_\_\_

HOW DID SYMPTOMS OCCUR? \_\_\_\_\_

### SYMPTOMS

**Please Circle All the Following Symptoms you have NOW.**

	Side	Pain 1-10	Side	Pain 1-10
Headaches		Pins/Needles in legs, feet, toes	R / L	Sinus Trouble
Neck Pain	R / L	Numbness in legs, feet, toes	R / L	Difficult Breathing
Stiff Neck	R / L	Pain in legs, feet, toes	R / L	Asthma
Fainting/Dizziness		Chest pain	R / L	Previous heart attack
Pins/Needles in arms, hands, fingers	R / L	High Blood Pressure/ Low Blood Pressure		Joint Swelling
Numbness in arms, hands, fingers	R / L	Pain between shoulder blades	R / L	Stomach Pain
Pain in arms, hands, fingers	R / L	Shoulder Pain	R / L	Bowel Changes
Mid Back Pain	R / L	Elbow Pain	R / L	Bladder Changes
Low Back Pain	R / L	Foot/Ankle Pain	R / L	Epilepsy
Hip Pain	R / L	Spinal Curve/ Scoliosis		Cancer

Other \_\_\_\_\_

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

What aggravates your symptoms? \_\_\_\_\_

What gives you relief of your symptoms? \_\_\_\_\_

Are you presently being treated for any other condition? Yes No If yes, what? \_\_\_\_\_  
By who? \_\_\_\_\_

Have you ever had prior Chiropractic Care? Yes No If yes, who? \_\_\_\_\_

(For Doctor's Use Only)

ONSET: \_\_\_\_\_ ETIOLOGY: \_\_\_\_\_

HX OF BP: \_\_\_\_\_ PRIOR TX: \_\_\_\_\_

FAMILY CHIROPRACTIC CARE CENTER, INC  
Dbu Gillis Chiropractic Clinic

INFORMED CONSENT- CHIROPRACTIC OFFICE

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 we use as a Doctor of Chiropractic is spinal manipulation therapy. We will use that procedure to treat you. The doctor may use his 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/Examination/Treatment:** In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Activator instrument spinal/extremity adjustment	palpation
Orthopedic testing	range of motion testing	vital signs
Basic neurological exam	muscle strength testing	hot/cold therapy
Postural analysis testing	x-ray/radiographic studies	electrical stimulation
Rehabilitation/core strengthening	manual traction adjustment	ultrasound
Cold laser therapy	spinal segmental traction	trigger point therapy

**The material risks inherent in chiropractic adjustment.** As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. However studies have shown that any observed association between vertebral artery dissection (VAD) and stroke with CMT is likely attributed to patients with an undiagnosed VAD who seek care for neck pain and headache before the onset of a stroke.(i) As a result we examine our patients thoroughly before initiating any treatment to be sure that treatment is appropriate. 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 my attention, it is your responsibility to inform the doctor.

**The probability of those risks occurring.** Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

**Soreness:** It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you experience after exercise.

**Fracture:** Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation are utilized for this type of patient.

**TIA/Stroke Overview:** Spinal manipulation is clearly one of the safest forms of treatment for cervical spine pain. The incidence of serious events, strokes, or death is very rare.(ii) Researchers found no evidence of excess risk of VBA stroke associated chiropractic care compared to primary care.(iii) The risk was a low as 1.46 adverse events per 10,000,000 manipulations.(iv) The risk of artery dissection was a low as 1 per 5,846,381 cervical manipulations(v)

**What about NSAIDS and Tylenol:** To put it in perspective, non steroidal anti-inflammatory drugs (NSAIDS) kill approximately 16,500 people per year annually in the US.(vi) And Tylenol toxicity is now the leading cause of liver failure in the US.(vii,viii) Spinal manipulations is safer than NSAIDS by a factor of several hundred times. (ix)

**Note:** Screening tests are performed when necessary to rule out high risk patients. Alternative spinal adjusting is utilized when necessary to minimize potential risks.

**Ruptured/Herniated Disc:** There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

**Other complications include but are not limited to:** fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

**The availability and nature of other treatment options:**

Other treatment options for your condition may include:

Self administered, over-the-counter may include:

Medical care and prescriptions 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 or undertreated.** 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. Early intervention to restore normal function and compliance with the treatment program are both essential in an effort to prevent the condition from progressing to a chronic pain state. (x,xi,xii,xiii,xiv,xv)

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

I have read the above explanation of the chiropractic adjustment and related treatment. I will discuss it with Dr. Gillis, if I have any questions regarding the above information. 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 of the risks, I hereby give my consent to that treatment.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Doctor: \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT TREATMENT CONSENT FORM**

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.

I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

**Financial Responsibility / Assignment of Benefits**

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Family Chiropractic Care Center, Inc. 1905 Lathem Ave. Lima, OH 45805.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

List of prices (subject to change):  
Chiropractic Adjustment: \$40.00, \$45.00  
Examinations: \$30.00, \$35.00, \$75.00  
Therapy: \$15.00-\$20.00/each, Decompression \$30.00  
X-rays: \$40-\$105 each  
Forms/Copies: \$5.00-\$20.00  
Supports/Brace: Prices Vary

**Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent**

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

\_\_\_\_\_  
Patient Name/Date

\_\_\_\_\_  
Patient/Guardian Signature/Date

# GILLIS CHIROPRACTIC CLINIC

Family Chiropractic Care Center, Inc.

1905 Lathem Avenue, Lima, OH 45805

419-228-0000

## Patient Acceptance of Liability

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### POTENTIAL NON-COVERAGE ON THE FOLLOWING DUE TO PLAN:

- Exams: \$30.00-\$75.00
- 1-2 Region Spinal Adjustment: \$40.00
- 3-4 Region Spinal Adjustment: \$45.00
- Therapy: \$10.00-\$20.00, Decompression \$30.00
- Dry Needling \$40.00
- Extremity Adjustment \$15.00
- X-Rays: \$40.00-\$105.00
- Supports/Braces/Supplements (prices vary)

I, the above named patient, have received/purchased the above named service/item from Gillis Chiropractic Clinic. If applicable, Gillis Chiropractic Clinic will bill my health insurance. I fully understand that if my insurance company denies any service/item as a "non-covered service/item" and/or states on my explanation of benefits "not patient's responsibility" it will be completely my responsibility for payment.

The above service/item is a doctor recommendation and I understand it is my choice to receive/purchase and maybe completely my RESPONSIBILITY FOR PAYMENT.

All items are non-refundable.

X \_\_\_\_\_

Patient Signature/Date