Jerian Chiropractic LLC 1999 W. Sunset Rd. Suite 4 Henderson, NV 89014
Ph: 702-454-9700 Fax: 702-454-1955

Welcome to Jerian Chiropractic! So that we may serve you best, please answer the following questions as completely as possible. Please ask if you have questions about anything relating to your care in our office.

Date: _____

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: ____ Zip: _____

Home ph: _____Cell ph: _____

Social Security #: _____ Date of Birth:_____/_____/_____ Gender: M F

Occupation: _____ Employer: _____

Work address: _____ Work ph: _____

□ Single □ Married-Spouse name: _____ □ Divorced □ Widowed

□ Life Partner-name: _____ Number of children: _____

Emergency Contact Name: _____Phone number: _____Relationship: _____

Who may we thank for referring you to us? _____

CURRENT HEALTH CONDITION:

Briefly describe your main concern/health problem: _____

Was it caused by: □ Auto accident □ Work injury □ Other: _____ □ Don't know

When did the symptoms first start? _____

If you are experiencing pain, rate its severity: no pain 1 2 3 4 5 6 7 8 9 10 severe

Other symptoms: □ Burning □ Tingling □ Numbness □ Pressure □ Other: _____

What have you done to treat the symptoms? □ Ice □ Heat □ Massage □ Rest
□ Exercise □ Chiropractor □ Over-the-counter medication □ Prescription medication
□ Physical Therapist □ Medical Doctor □ Osteopathic Doctor □ Other: _____

What makes it worse? _____ Better? _____

Does it interfere with… □ sitting □ standing □ walking □ sleep □ leisure time □ family time
□ exercise □ work □ other: _____

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor- 1 2 3 4 5 6 7 8 9 10 -Excellent

Stress can cause or accelerate spinal damage. Rate your overall stress level during the last 90 days.
Low- 1 2 3 4 5 6 7 8 9 10 -High

Currently, during most of the day I: □ sit □ stand □ walk □ do desk/computer work □ drive
□ talk on the phone □ heavy lifting □ mechanical work

Habits:	**None**	**Light**	**Moderate**	**Heavy**	
Tobacco:	□	□	□	□	
Alcohol:	□	□	□	□	
Exercise:	□	□	□	□	
Restaurant/fast food:	□	□	□	□	
Soda/coffee:	□	□	□	□	□ Diet/Splenda/Artificial Sweeteners?

Prescription and non-prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (**please include all prescription and over-the-counter medications plus any vitamins or supplements**)

□ I am not taking any medications or over-the-counter drugs/vitamins/supplements.

Name	**Condition being treated**	**How long have you been taking this?**

PAST HEALTH CONDITION:

Research shows that your spine should be checked regularly. When was your last complete **spinal**

examination (including x-rays)? _____ Have you been a chiropractic patient before? Y N

If yes, when was your last adjustment? _____ Why did you stop? _____

Have you ever had:	**No**	**Yes**	**Briefly explain, including dates:**
Car accident(s)? (no matter how minor)	□	□	_____
Falls/Other accidents?	□	□	_____
Surgery? (even if elective)	□	□	_____
Other hospitalizations?	□	□	_____

Please check any of the following health challenges you have experienced, even if they do not seem related to your current health problem…

□ Allergies/Asthma	□ Arthritis	□ Artificial bones/joints
□ Back pain	□ Cancer	□ Circulatory/Vascular
□ Depression/Anxiety	□ Diabetes	□ Digestive problems
□ Dizziness/Vertigo	□ Ear infections	□ Headaches/Migraines
□ Heartburn/Acid reflux	□ Heart problems	□ Immune System Disorder
□ Infertility	□ Menstrual cramps	□ Neck pain
□ Numbness/Tingling	□ Osteoporosis	□ Pacemaker
□ Sinus problems	□ Skin conditions	□ Other: _____

If you are accepted as a chiropractic practice member, what are your goals with respect to your healthcare in our office?

□ Temporary relief of symptoms; help with current problem only
□ Correction of problem; help ensure that my health concerns do not become an ongoing issue that will impact my future health
□ Maximum wellness; I want to be healthier five years from now than I am today

Females: Are you pregnant?
□ **NO**: I certify to the best of my knowledge I am not pregnant and the doctor(s)/staff have my permission to x-ray.
□ **YES**: I agree to receive treatment without the benefit of x-rays due to my pregnancy. I release the doctor(s) and staff of Jerian Chiropractic from any liability due to not taking x-rays.

Initials: _____

The statements made above are accurate and truthful to the best of my knowledge. Jerian Chiropractic will not be held responsible for any pre-existing medically diagnosed conditions. I understand it is my responsibility to inform this office of any changes to the information I have provided. Jerian Chiropractic will not be held responsible for any problems resulting from my failure to update any of the above information.

Patient/Guardian signature: _____ **Date:** _____

WEBSITE ENROLLMENT: Receive info related to office hours and holidays, a newsletter and access to the Members Only section of the website!

Email address: _____

The office will NEVER request nor send information of a personal, health related nature by email. You may opt-out at any time. Please view our complete website privacy policy at www.jerianchiropractic.com

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day in the United States alone by Doctors of Chiropractic.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian signature: _____ Date: _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary and to the chiropractic care, including spinal adjustments, as reported following my assessment.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

Witness Signature (office): _____ Date: _____

FINANCIAL POLICIES AND HEALTH INSURANCE

1. Payment is expected at the time services are rendered. Until your benefits are verified with your insurance company all charges are due in full at the time of service. We will make every effort to obtain this information on your first visit, but cannot guarantee it.
2. Most insurance policies have limits on chiropractic care. You will be informed of these limits and Jerian Chiropractic will do its best to keep track of those limits; however, **the patient is ultimately responsible for keeping track of those limits** and Jerian Chiropractic will not be held responsible for charges incurred when those limits are reached or exceeded.

□ I do not have health insurance or I do not wish to use/bill my health insurance.

Who is the policy holder for this insurance? Name: _____

Date of Birth: ____/____/_____ SSN: _____ Employer: _____

Relationship to patient: □ Spouse □ Parent □ Other: _____

Is the patient covered by a secondary insurance? Y N

If yes, who is the cardholder? _____ Date of Birth: ____/____/_____

SSN: _____ Employer: _____

Relationship to patient: □ Spouse □ Parent □ Other: _____
SECONDARY INSURANCE: Jerian Chiropractic will submit claims to a secondary insurance as a courtesy to you. However, payment according to your primary insurance benefits is expected at the time of service. Once confirmatory payment is made from the secondary provider, other payment arrangements may be made. I understand and agree to the above statements. **Initials**: _____

BLUE CROSS/BLUE SHIELD, MEDICARE, and/or _____:
This office does not accept assignment (payment) from the above listed companies. You are responsible for paying in full all charges at the time of service. Reimbursement will be made by the insurance company directly to you. In the unlikely event Jerian Chiropractic receives payment, it will be credited to your account and may be used/refunded upon request. **Initials**: _____

I understand and agree that health and/or accident insurance policies are an arrangement between the insurance carrier and the insured. ***I understand that I am financially responsible for all charges, including those not reimbursed by insurance or third party payors.*** I authorize Jerian Chiropractic to bill my insurance and release any necessary information to any insurance company, its agents, or other third parties in order to obtain benefits, obtain payment or facilitate claim processing. I assign directly to Jerian Chiropractic all insurance benefits, if any, otherwise payable to me (exceptions listed above). All balances remaining over 10 days will be sent to a collection agency and will be subject to additional charges, including, but not limited to, interest, overdue payment fees, collection agency fees and/or attorney fees. Returned checks are subject to an additional charge of $25.00.
Patient/Guardian signature: _____ Date: _____

The patient is ultimately responsible for payment on this account, unless the patient is a minor or another party has chosen to accept responsibility. **IF someone else is liable for payment, Name**: _____
Relationship to patient: _____ Date: _____ Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

Staff Signature Date