Finn Chiropractic Center

*office staff _____DL

Dr. Jennifer Finn
Dr. Krysten Schab
203 Greenwood Ave Unit 2
Clarks Summit, PA 18411
(570) 586-3440

ADULT PERSONAL INFORMATION

Legal Name _____**Date** _____

Address_____

_____

Cell phone _____ Email _____

Date of Birth _____ **Age** _____ **Sex** _____ Gender _____Pronouns_____

Preferred Name (if different than legal name) _____ Occupation _____

Marital Status (check) ___Single ___Married ____Partnership ___Separated ___Widowed ____Divorced

Name of Spouse _____Do you have any children? If so, how many _____

Emergency Contact _____ **Relationship** _____ Phone (____) _____

ADDITIONAL INFORMATION

Can we leave a detailed message on your cell phone? _____ If alternate # please indicate_____

Can ***we leave appointment related info*** with anyone answering your phone? _____

Would you like to receive a text appointment reminder? _____

Do you give permission for the doctor to text you? _____

Would you like to receive *email updates* from the office and staff: _____ We promise not to spam!

How did you hear about Finn Chiropractic Center? _____If you were referred by someone, please let us know! **We are grateful for referrals** and would like to thank them personally!

Reason for Seeking Chiropractic Care

Please check reason(s) for care:

____ **Wellness Focused** ___ Family/Friend Recommended ___Not sure

____ **Problem Focused** and if so, describe: _____

Is it due to an *auto-accident or worker's compensation case*? _____

Problem/Pain/Discomfort

If pain/discomfort is involved, please answer the following:

When did it start? _____

When does it occur? ___constant ___AM ___PM ___comes & goes ___other

How frequent does it occur? ___constant ___frequent ___occasional ___intermittent

Severity of pain on a scale of 1 (mild) to 10 (severe): _____

Type of pain/discomfort: ___dull ___sharp ___achy ___shooting ___stiffness ___throbby ___burning

___numbness ___tingling ___swelling ____other and if so, explain _____

***Since it started, it is currently*:** _____about the same _____ getting better _____ getting worse

It is impacting: ___work ____walking ___lifting ___sitting ___reclining ___bathing ___bending ___driving

___exercise ___sleep ___standing ___other: _____

Have you had this or something similar before? _____

Have you seen someone for this problem and if so, who? _____

What have you done to help relieve this problem? _____

_____ Did it help? _____

Health History

Do you currently have *any (other) health concerns*? If so, please explain

_____

_____

Did you have *covid, covid vaccine, and/or monoclonal antibodies*? If so, please explain

_____

How would you rate *your current health*? Poor Fair Average Good Excellent
How would you rate *your family's health*? Poor Fair Average Good Excellent

Are you currently seeking medical attention and if so, for what? _____

_____

_____

Have you received chiropractic care before? _____ If so, date of last visit _____
Is anyone in your family currently under chiropractic care? If yes, who? _____

Physical Stress

Please **check** any of the following that **currently apply (C)** or have applied in **the past (P)**

___ Accident Prone
___ Repetitive Tasks
___ Prolonged Driving
___ Prolonged Standing
___ Other
___ **Surgery**
___ Automobile Accident
___ Slips/Falls
___ Manual Labor
___**Bone Fracture or Dislocation**
___ Sports/Exercise
___ Poor Posture
___ Hospitalizations

Explain any of the above: _____
_____

Chemical Stress

Please list any current **medications** and/or supplements

_____
_____
_____

Please **check** any of the following:

___ Exposure to secondhand smoke
___ **Smoker**
___ **Allergies** If so, explain _____
___Caffeine
___ Alcohol
___Recreational Drugs
___ Junk food

Emotional Stress

Please **check** any of the following:

___ Relationships
___ Career
___Family
___Finances
___ School
___ Depression
___Anxiety
___ Attention/ Focus
___ Easily Irritated

What do you feel is the *primary stress* in your life? _____

Wellness History

What does wellness mean to you? _____

What activities or modalities support your health and wellness journey in addition to chiropractic?

_____

Anything else we should know that would help us best serve you? _____

_____

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 the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to a third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

(Signature of Patient or Guardian)

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other procedures including various modes of physical therapy, if necessary. I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here, **Dr. Jennifer Jaffe Finn and Dr. Krysten Schab** and/or other licensed Physicians of Chiropractic who may treat me now or in the future in this office.

The Nature of Chiropractic Treatment: The doctor will use her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, and others, may be used.

Possible Risks: I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment. In the rare event there are specific risks pertaining to my individual case, the doctor will address these with me directly. The risks of complications due to chiropractic treatment have been described as "rare about as often as complications are seen from taking a single aspirin tablet."

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I intend to receive the recommended treatment, and hereby give my full consent to treatment.

To be completed by the patient's representative if necessary (if the patient is a minor or is physically or mentally incapacitated).

X ____

(Initial)

Consent for Use & Disclosure of Health Information to Family, Friends, & Others Involved in Your Care

I give **FINN CHIROPRACTIC CENTER** consent to use and/or disclose my protected health information (PHI) to my family, close friends, or others involved in my care and/or payment of my care pertaining to health information and treatment, appointments, and financial agreements. Please list the names and relationship of those individuals you would like us to share information with, as well as any restrictions.

Name	Relationship	Restrictions

I have the right to withdraw this consent at any time. I must do this in writing to **Finn Chiropractic Center**. This consent is good unless and until I withdraw it in writing.

X ____
(Initial)

Consent for Use & Disclosure of Health Information

By signing this form, I give this clinic, consent to use and/or disclose my protected health information (PHI) to carry out treatment, payment or health care operations.

I have the right not to sign this consent. If I refuse to sign this consent, this clinic may refuse to not provide me with treatment until I consent.

This clinic has provided me with a copy of its Notice of Privacy Practices which describes how this clinic may use and disclose my health information. I have the right to review this Notice before signing this consent.

This clinic may change the Notice of Privacy Practices as needed. I may obtain a current copy of this clinic's Notice of Privacy Practices by contacting this clinic's Privacy Officer.

I have the right to withdraw this consent at any time. I must do this in writing to this clinic. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then this clinic, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

This consent is good unless and until I withdraw it in writing.

X ____
(Initial)

Acknowledgement of Notice of Privacy Practices Policy

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

X ____
(Initial)

Cancellation Policy

All patients must call to cancel their appointments *at least 24 hours in advance*. Failure to do so will result in a fee of $50 for a new patient appointment and $20 for patients scheduled for adjustments. This is to ensure that our clinic can accommodate all patients in a timely manner. We understand that unforeseen circumstances may arise, but please keep in mind that we have a waitlist of patients who are in need of our services. By not cancelling or calling, we are unable to offer these appointments to those on the waitlist.

X ____
(Initial)

INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected **"INSURANCE ASSIGNMENT"** as the method of choice to take care of your financial obligation with this office. It is important that you realize that in this office we offer the option of **"INSURANCE ASSIGNMENT"** strictly as a courtesy to our patients, and as a result, patients must understand and agree to the following:

1. That you are considered a" cash "patient until you bring in a current insurance card and this office qualifies and accepts your coverage.

2. That you are ultimately responsible for full payment of any and all services rendered.

3. That you must pay all deductibles in full.

4. That co-insurance and co-pays must be paid at the time of service, or at the end of each week if you are coming several times a week. You may pay with cash, check or credit card (except American Express). We also accept HRA Spending Account credit cards.

5. That if your carrier has not paid a claim within 60 days of submission, you are responsible for taking an active part in the recovery for your claim, and that after 90 days you will be responsible for payment in full of any outstanding balance.

6. If you have an outstanding balance on your account, we will bill you via mail. *Any bills not paid within 60 days are subject to a $10* ***late fee****. Any bills not paid within 90 days will be forwarded to a collection agency.*

This insurance assignment policy must be followed, and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and you accept full responsibility.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Witness: _____