FINN CHIROPRACTIC CENTER

PATIENT INFORMATION

Date:_____

Last Name: _____

First Name:_____ Middle Initial: _____

Sex: Male ___ Female ___ Date of Birth: _____ Age: _____

Home #: _____ Cell #: _____ Work #: _____

Where do you prefer to receive calls? _____

Can we leave a detailed a message on your home phone & cell? ( ) Cell ( ) Home

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

Would you like to receive a text appointment reminder? _____

Cell Carrier: _____

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

Patient Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Relationship: Spouse _____ Parent _____ Other _____

Email Address (to receive newsletter): _____

INSURANCE INFORMATION

Primary Policyholder's Name: _____ Date Of Birth: _____

Address (**if different than above**): _____

City: _____ State: _____ Zip: _____

Patient relationship to primary policyholder: self _____ spouse _____ child _____

How did you hear about our office? _____

SYMPTOMS

Reason for visit _____

When did you first notice these symptoms? _____

Is this condition getting progressively worse? _____
Where specifically is the problem (s) located? _____

Which activities are difficult to perform (**please circle**)? Sitting Standing Walking Bending Lying Down Other

Type of Pain (**please circle**): Dull Sharp Aching Shooting Spasm

Throbbing Burning Numbing Tingling Stiffness Swelling

Rate the severity of your pain (1 is mild pain or discomfort, to 10 is severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

Medication ____ Surgery ____ Physical Therapy ____ Other ____

Name of other doctor(s) who have treated you for your condition? _____

_____

_____

List any types of **SURGERIES** which you have had and the dates on which they occurred: _____

_____

Please list all **MEDICATIONS** you are currently taking: _____

_____

_____

Any Allergies: _____

ACCIDENT HISTORY

List all **ACCIDENTS** (cars, sports, etc) _____

_____

_____

List all **BROKEN/FRACTURED** bones and the year it occurred _____

_____

_____

Have you ever been treated by a chiropractor before? If so, when was your last visit? _____

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 parent if patient is a minor)

FINN CHIROPRACTIC CENTER

INFORMED CONSENT TO CHIRPROACTIC 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, 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 also be used.

Possible Risks: I understand that 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 the taking of 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)

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Printed Name of Guardian Or Representative	**Signature**	**Date**

FINN CHIROPRACTIC CENTER

Consent for Use and Disclosure of Health Information

Date of Consent: _____

Patient Name: _____
Date of Birth: _____

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.

_____

Signature of Patient or Legal Representative *Date*

FINN CHIROPRACTIC CENTER

Acknowledgment of Notice of Privacy Practices

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.

_____

Name of Patient or Legal Representative *Date*

_____

Signature of Patient or Legal Representative *Date*

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: _____

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

Patient Name: _____

Date of Birth: _____ Date of Consent: _____

By signing this form, 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.

_____

Signature of Patient or Legal Representative *Date*