Norfolk Chiropractic Center

425 West 20th Street, Suite 6
Norfolk, VA 23517

1 PATIENT INFORMATION

Date_____

Social Security # _____

Legal Name_____
Last Name

_____
First Name Middle Name

□ Male □ Female

D.O.B._____ Age_____

Address_____

City_____ State_____ Zip_____

Home ph. (_____) _____

Cell ph. (_____) _____

Best Number to reach you_____

□ Married □Single □ Widowed
□ Separated □Divorced □ Minor

Employer/School & Address_____

_____

Employer/School ph. (_____) _____

Occupation_____

2 INSURANCE INFORMATION

NO HEALTH INSURANCE COVERAGE □

Policy Holder's Name_____

Relationship to Patient_____

Insurance Company_____

ID#_____

Group #_____

Is patient covered by additional insurance? □ Yes □ No

Additional Insurance Carrier_____

Policy Holder's Name_____

ID#_____

Group#_____

If we participate with your insurance carrier, do you want us to file for you? □ Yes □ No

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate the schedule of care that has been determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at a rate of 1.5% per month (18% APR).

_____
SIGNATURE of Patient, Parent or Guardian

_____
PRINTED NAME of Patient, Parent or Guardian

3 EMERGENCY CONTACT

In case of emergency, please contact:

Name_____

Relationship_____

Home # (_____) _____

Work/Cell # (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? □Yes □No Date_____

Type of accident □ Auto □ Work
□ Home □ Other: _____

To whom have you made a report of your accident?

□ Auto Insurance □ Employer
□ Worker's Comp. □ Other: _____

5 MEDICATIONS ALLERGIES VITAMINS/SUPPLEMENTS

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may have to disclose your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, it is your responsibility to notify us in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read this consent policy and agree to its terms. I acknowledge that I may request a copy of this notice.

_____ _____ _____

Printed Name Signature Date

_____ _____

Authorized Provider Representative Date

If patient is a minor:

_____ _____

Child's Name Parent's/Guardian's Name

_____ _____

Parent's/ Guardian's Signature Date

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. I authorize payment directly from my insurance company to Norfolk Chiropractic Center. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

I understand that if wish to file a Med-Pay claim through an auto insurance carrier, I am responsible for my visit balance at the time services are rendered. I will be given an itemized receipt of payment so that I may submit for reimbursement.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30-day period, I am subject to a 1.5% per month interest (19% APR). If I have an outstanding balance that may be served to a collection agency, I will be responsible for additional fees and penalties.

I understand that this office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful you will be expected to take responsibility for any outstanding balance.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member of Norfolk Chiropractic Center responsible for any errors or omissions that I may have made in the completion of this form.

I understand Norfolk Chiropractic utilizes *ReSubmitIt* for all returned checks, which can result in $55.00 in returned check fees. These fees will be my responsibility.

_____ _____ _____

Printed Name Signature Date

_____ _____

Authorized Provider Representative Date

<u>If patient is a minor:</u>

_____ _____

Child's Name Parent's/Guardian's Name

_____ _____

Parent's/ Guardian's Signature Date

INFORMED CONSENT

PATIENT NAME: _____ DOB: _____

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 used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my 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

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___spinal manipulative therapy ___palpation ___vital signs ____range of motion testing
___orthopedic testing ___basic neurological testing ___muscle strength testing
___ postural analysis testing ___radiographic studies
___EMS ___cold therapy ____decompression ___ core/cervical strengthening exercises
____ **ALL OF THE ABOVE**

(Please initial next to each procedure you consent to)

The risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection cause by chiropractic manipulation of the neck had been the subject of ongoing medical research and debate. The most current research on the topic is that there is no relationship. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest
- Medical care and prescription 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

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.

INFORMED CONSENT (CONTINUED)

CONSENT TO TREAT (MINOR)

I hereby request and authorize Dr. Niblo to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Niblo and/or office staff and have had my questions answered to my satisfaction. 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.

_____ _____ _____

(PRINT NAME) **(SIGNATURE)** **(DATE)**

_____ _____

(DOCTOR'S SIGNATURE) **(DATE)**

OFFICE POLICIES

Thank you for choosing Norfolk Chiropractic Center. We realize that you have a choice in chiropractic care and are pleased that you have chosen to seek care with us. The staff at Norfolk Chiropractic Center strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Please feel free to let us know if you have any questions regarding our policies.

1. It is important that you notify the office if you have suffered a new injury so that we may better prepare for your appointment.
2. Norfolk Chiropractic Center accepts most insurance plans. It is your responsibility to notify the office of any changes of information, including name change, change of address, phone numbers and insurance. Failure to do so could cause delay or denial of insurance payment.
3. All co-payments, deductibles and/or co-insurance must be paid at the time services are rendered. This arrangement is part of your contract with your insurance company.
4. FOR HMO/PPO/MANAGED CARE PATIENTS: The office staff will be happy to assist you with the referral process; however, ultimately it is the patient's responsibility to make sure all visits are authorized by a referral.
5. Patients filing a Med-Pay claim through auto insurance are responsible for visit balance at the time services are rendered. An itemized statement will be given for submission of reimbursement.
6. An adult **must** attend to children at all times.
7. No food or drink is allowed in the office.
8. Cell phones must be placed on vibrate or silent. If you must take a phone call, please do so in the hallway outside the office.
9. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely care. A cancellation or no show fee of **$45** will be charged if **no notice** or less than **24 hour** notice of cancellation of an appointment is given. **No charge** will incur if a 24 hour notice is given for cancellation of an appointment.
10. If copies of medical records are needed, a fee of $ .50/page will be applied.
11. If any FMLA or Disability forms are requested to be filled out by Dr. Niblo, a fee of $25 will be assessed for **each** request.

I have read and fully understand the above office policies.

_____ _____

Signature Date

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Name: _____

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Norfolk Chiropractic Center.

_____ (Patient Initials) I consent to receive text messages from Norfolk Chiropractic Center at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____
(Carrier :_____)

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

Norfolk Chiropractic Center does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan-contact your carrier for pricing plans and details.

Revocation / Opt Out:

_____ I hereby revoke my request for future communications via email and/or text messages.

_____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health information via email.

_____ I hereby opt out of receiving any communications via email and/or text messages, including appointment reminders, feedback, and general health information.

Note: *This revocation only applies to communications from Norfolk Chiropractic Center.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____ *Witness:* _____

CHECK THE FOLLOWING AS THEY APPLY TO YOU

Yes	No	GENERAL SYMPTOMS/ CONDITIONS	Yes	No	GASTRO-INTESTINAL	Yes	No	EYE/EAR/NOSE/ THROAT	Yes	No	RESPIRATORY
		Migraines			Belching or Gas			Sinusitis			Chronic cough
		Allergy			Acid Reflux			Asthma			Difficulty Breathing
		Bronchitis			Heart burn			Deafness			Spitting Phlegm
		Chills			Colon Trouble			Earache			
		Convulsions			Constipation			Ear Discharge			**Genito-Urinary**
		Dizziness			Diarrhea			Ear Noises			Frequent Urination
		Fainting			Gall bladder			Thyroid Problem			Bladder Control
		Fatigue			Hemorrhoid			Frequent Colds			Kidney Infections
		Headache			Jaundice			Hay Fever			Kidney Stones
		Loss of Sleep			Liver Trouble			Nasal Obstruction			Painful Urination
		Loss of Weight			Nausea			Nose bleeds			Prostate Trouble
		Nervousness			Stomach Pain			Pain in Eyes			
		Night Sweats			Vomiting			Poor Vision			**Neurological**
		Numbness			Bloody Stool			Blurred Vision			Anxiety
		Measles			Irritable Bowel			Sore Throats			Mood Swings
		Polio			Ulcers			Tonsillitis			Phobias
		Alcoholism									Mental Disorders
		Anemia			**Cardiovascular**			**Muscles/Joints**			M.S.
		Diabetes			High Blood Pressure			Backache			Epilepsy
		HIV			Strokes			Shoulder Pain			Memory Loss
		Tuberculosis			Low Blood Pressure			Stiff neck			Depression
		Arthritis			Chest Pain			Foot Trouble			
		Mumps			Heart Trouble			Hernia			Females Only
		Cancer			Poor Circulation			Painful Tail Bone			Irregular Cycle
		Serious Injury			Rapid Heart			Spinal Curvature			Cramps
					Slow Heart			Swollen Joints			Hot flashes
		Others?			Swollen Ankles			Tremors			Painful Periods
		1.			Varicose Veins			Twitching			Are You Pregnant
		2.			Pacemaker			Spinal Disc Disease			
		3.						Dislocated Joints			

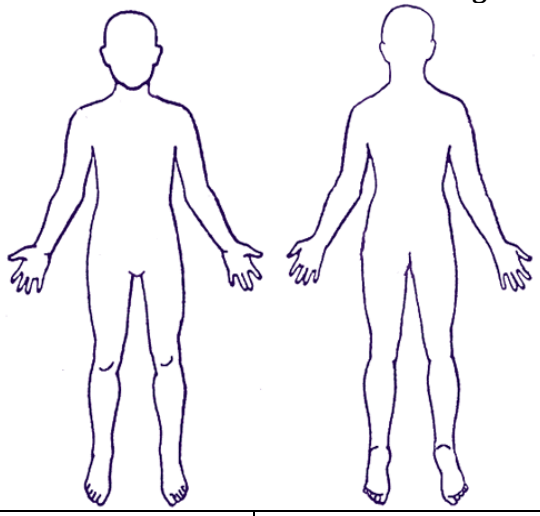
FAMILY HISTORY

	Stroke	Bad Posture	Heart Trouble	High Blood	Cancer	M.S.	Headache	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteo-porosis	Scoliosis	Diabetes
Father																
Mother																
Brother																
Sister																
Child																
Child																

MAJOR COMPLAINT INFORMATION

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = Ache **O = Other**
B = Burning **P = Pins and Needles**
N = Numbness **S = Stabbing**



Complaint #1	**Type of Pain:**	**Worse with Which Activities?**	**Result of:**
_____ _____ _____ _____ _____ Began? _____ Have you had this in the past? □ Yes □ No Is it getting worse? □ Yes □ No □Constant	□ Aching □ Burning □ Deep □ Dull □ Numb □Throbbing □ Sharp □ Tight □ Stiff □Tender □ Tingling □ Sore □ Shooting □Throbbing	□ Lying on Back □ Lying on Side □ Lying on Stomach □ Turning Over □ Getting in/out of car □ Dressing Self □ Pushing □ Pulling □ Lifting □ Reaching □ Other_____ □ Stooping □ Bending □ Walking □ Sitting □ Twisting/ Turning □ Coughing □ Standing □ Climbing □ Sneezing	□ Auto Accident □ Work Injury □ Other: _____ _____ _____ _____
Complaint #2	**Type of Pain:**	**Worse with Which Activities?**	**Result of:**
_____ _____ _____ _____ _____ Began? _____ Have you had this in the past? □ Yes □ No Is it getting worse? □ Yes □ No □Constant	□ Aching □ Burning □ Deep □ Dull □ Numb □Throbbing □ Sharp □ Tight □ Stiff □Tender □ Tingling □ Sore □ Shooting □Throbbing	□ Lying on Back □ Lying on Side □ Lying on Stomach □ Turning Over □ Getting in/out of car □ Dressing Self □ Pushing □ Pulling □ Lifting □ Reaching □ Other_____ □ Stooping □ Bending □ Walking □ Sitting □ Twisting/ Turning □ Coughing □ Standing □ Climbing □ Sneezing	□ Auto Accident □ Work Injury □ Other: _____ _____ _____ _____
Complaint #3	**Type of Pain:**	**Worse with Which Activities?**	**Result of:**
_____ _____ _____ _____ _____ Began? _____ Have you had this in the past? □ Yes □ No Is it getting worse? □ Yes □ No □Constant	□ Aching □ Burning □ Deep □ Dull □ Numb □Throbbing □ Sharp □ Tight □ Stiff □Tender □ Tingling □ Sore □ Shooting □Throbbing	□ Lying on Back □ Lying on Side □ Lying on Stomach □ Turning Over □ Getting in/out of car □ Dressing Self □ Pushing □ Pulling □ Lifting □ Reaching □ Other_____ □ Stooping □ Bending □ Walking □ Sitting □ Twisting/ Turning □ Coughing □ Standing □ Climbing □ Sneezing	□ Auto Accident □ Work Injury □ Other: _____ _____ _____ _____