RIVER CITY CHIROPRACTIC

Welcome!

River City Chiropractic extends a warm and personal welcome to you on behalf of the doctor and staff. Our goal is to provide you with the finest health care as well as offer you many informative and entertaining educational opportunities.

CONFIDENTIAL PATIENT INFORMATION			**Date: / /**
First Name:	Last Name:	Middle Initial:	DOB:
Address:	City	State:	Zip Code:
Phone:	Other Phone:		
Email:		Sex: M F	
Marital Status:	# of Children:	Occupation:	
Emergency Contact:	Relation:	Phone:	
How did you hear about us?			
Who is your primary care physician?			

TRAUMAS / CURRENT HEALTH CONDITIONS

Have you ever had any significant falls, surgeries, or other injuries? Yes ☐ No ☐
- If yes, please explain:

Notable childhood injuries? ☐ Yes ☐ No If yes, please explain:

Any auto accidents? ☐ Yes ☐ No If yes, please explain:

What health condition(s) bring you into our office?

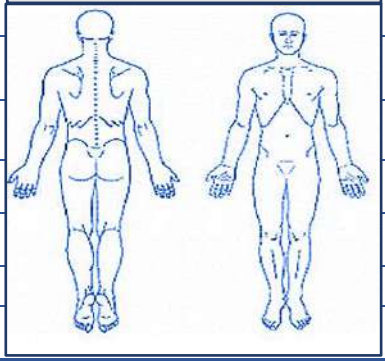
Have you received care for this problem before?

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort
X=Current O=past



Do you have any questions or concerns for the doctor? ☐ Yes ☐ No If yes, please explain below

Accident / Injury History

Insurance Information:

Responsible Party's Name:	
# 1 Insurance Company:	Adjuster:
Address:	
Phone Number:	Claim Number:
#2 Insurance Company	Adjuster:
Address:	
Phone Number:	Claim Number:
Have you retained an attorney? Name:	

1. Enter a full description of the accident, injury, or onset in the space below.

2. Enter the details of your condition during and immediately after your injury/onset.

_____ _____

Patient Signature Date

Automobile Accident Description

Please answer the question below. If you do not know the answer to any of the questions, do not answer that question.

1. Your Vehicle Type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
☐ Other _____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
☐ Other _____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in Traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
☐ Other _____

4. Time/Speed/Damage

Time of accident _____
Your vehicle's speed: _____ mph
Their vehicle's speed: _____ mph
Damage to your vehicle
☐ Mild ☐ Moderate ☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good
Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit…(object)
_____

6. Road Conditions

☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of Impact:
☐ Head-On ☐ Left Front ☐ Right Front
☐ Rear-End ☐ Left Rear ☐ Right Rear

7. Body Positions, etc.

Did you see the accident coming? ☐ Yes ☐ No
Were you braced for the impact? ☐ Yes ☐ No
Did you have a seat belt on? ☐ Yes ☐ No
Did you have a shoulder harness on? ☐ Yes ☐ No
Did driver side airbags deploy? ☐ Yes ☐ No
Did passenger side airbags deploy? ☐ Yes ☐ No
Did side airbags deploy? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What was the position of your headrest at the time of impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of your head at the time of impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

8. During the Accident

Did your body strike the inside of the vehicle? ☐ Yes ☐ No
If yes, describe: _____
Did you lose consciousness during the injury? ☐ Yes ☐ No
If yes, for how long? _____
Your vehicle's estimated damage? _____

Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled

Did police show up at the scene? ☐ Yes ☐ No
Was an accident report filled out? ☐ Yes ☐ No

9. After the Accident

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove Self ☐ Somebody Else ☐ Ambulance ☐ Police
Were X-rays done? ☐ Yes ☐ No
Was Lab work done? ☐ Yes ☐ No
Body parts X-rayed? _____
What lab work? _____
The X-rays revealed? _____
Treatments? ☐ Cervical Collar ☐ Ice Other: _____
Medications: _____
Follow up instructions: _____
_____

Check off your symptoms right after and a few days following:

☐ Headache	☐ Fatigue	☐ Cold hands
☐ Neck Pain	☐ Tension	☐ Cold feet
☐ Neck Stiffness	☐ Irritability	☐ Diarrhea
☐Fainting	☐ Shortness of breath	☐ Depression
☐ Ring in ears	☐ Mid back pain	☐ Anxious
☐ Loss of smell	☐ Low back pain	☐ Chest Pain
☐ Pain behind eyes	☐ Nervousness	☐ Sleeping problems
☐ Dizziness	☐ Loss of taste	
☐ Nausea	☐ Toe numbness	
☐ Confusion	☐ Constipation	

Others: _____

10. Treatment History

Fill in any other doctor(s) seen prior to your first visit to this office.

1. Dr. _____ First visit date: ____/____/____
Specialty: _____ X-rays done? ☐ Yes ☐ No
Types of treatment received? _____
Did treatments benefit you? ☐ Yes ☐ No Last visit date: ____/____/____

2. Dr. _____ First visit date: ____/____/____
Specialty: _____ X-rays done? ☐ Yes ☐ No
Types of treatment received? _____
Did treatments benefit you? ☐ Yes ☐ No Last visit date: ____/____/____

River City Chiropractic
1109 E. Polston Ave.
Post Falls, ID 83854

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

Patient Financial Policy

River City Chiropractic

1109 E Polston Ave

Post Falls, Idaho 83854

208-777-4000

In the interest of good communication and our continued commitment to provide high quality Chiropractic care, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choice for your care.

We are committed to support you in understanding your spinal health and will always present you with the best recommendations to treat your personal situation. To make these services affordable we are pleased to offer you the following payment options.

1. Check or Cash
2. Visa, Mastercard, Discover, American Express
3. Payment Plan

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office—this includes any treatment that is not a benefit of any chiropractic insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received.

Please make your questions and concerns known to our Billing Manger who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party)_____ Date_____

Patient Health information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this.

1. The patients understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke a consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date