Commerce
CHIROPRACTIC

Welcome to Our Office

Legal name: _____ Date: _____

What do you prefer to be called? _____

DOB: _____ /_____ /_____ Age: _____ Gender (Circle One): M / F

Address: _____City: _____ Zip: _____

Cell: _____ Work: _____

Marital Status (Circle One): M/S/D/W Social Security Number: _____

Email Address: _____

Preferred method of communication (Circle One):

Email / Home Phone / Cell Phone

Preferred Language: _____

Occupation: _____ Employer: _____

Primary care physician: _____

Phone:_____ Fax #:_____

Whom can we thank for referring you to our office? _____

Have you had chiropractic care before? _____ If so, when? _____

List your complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____
5. _____ For how long? _____

Surgery (Please include all surgeries)

1. _____ Year: _____

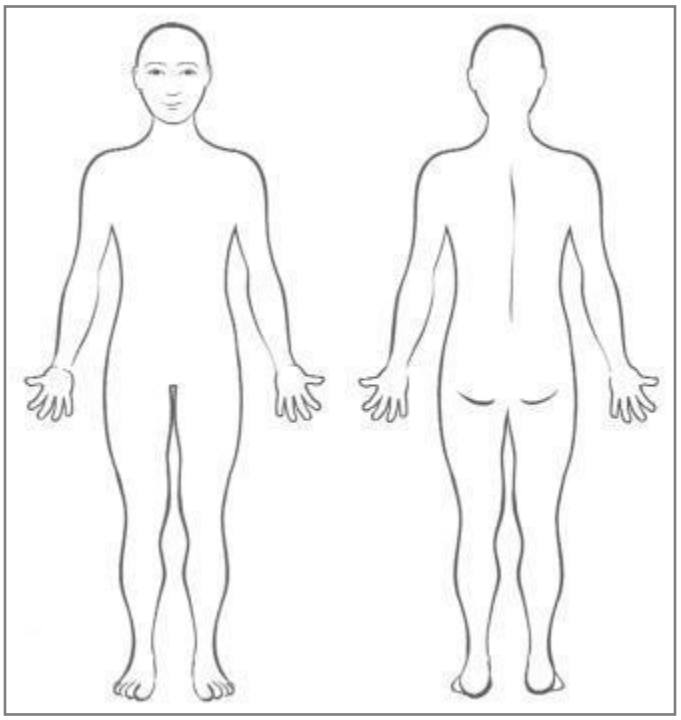
2. _____ Year: _____

3. _____ Year: _____

Are you now or have you suffered from any of the following:

- ☐ Stroke
- ☐ Fatigue
- ☐ Migraine
- ☐ Nervousness
- ☐ Arthritis
- ☐ Numbness
- ☐ Pregnant
- ☐ Spinal curvature
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Dizziness
- ☐ Headache
- ☐ Cancer
- ☐ Diabetes
- ☐ Swollen joints

Please mark your area of pain on the picture below



Please rate the intensity of your pain:

Absent 0 5 10 *Extreme*

Frequency:

☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Are symptoms:

☐ Getting worse ☐ Getting better ☐ Staying the same

CONSENT TO TREAT A MINOR CHILD:

I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature: _____ (Parent/Legal Guardian) Date: _____

FINANCIAL/INSURANCE POLICY:

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's Office will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

Policy Holder's name: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION

To: Richard W. Sadowski D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Signature: _____ Date_____

Terms of Acceptance

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. 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.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A Misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental pulses, resulting in lessening the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PURPOSE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____ have read and fully understand the above statements.
(Please Print)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic on this basis.

Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I acknowledge that Commerce Chiropractic Clinic's "Notices of Privacy Practices" has been provided to me. I understand I have the right to review Commerce Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Commerce Chiropractic Clinic. The Notice of Privacy Practices for Commerce Chiropractic Clinic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Commerce Chiropractic Clinic's duties with respect to protected health information. I give permission to Commerce Chiropractic Clinic to use my name, address, phone number, date of birth and social security number to contact my insurance company to verify my coverage and benefits and to check the status of my insurance claims. Commerce Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a re vised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ Date: _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority