CHIROMEDICA

Chiropractic Clinic

PATIENT UPDATE FORM

PLEASE PRINT CLEARLY

Date: _____

Name: (First)_____ (Last)_____
(M.I.)_____

Home
Address_____

City_____ State_____ Zip
_____

Home Phone☐ (____)_____ Work Phone☐ (____)_____Cell Phone☐ (
)_____

(Please indicate the preferred contact number)

Birth Date_____ Age_____ Sex M ☐ F ☐

Email
Address_____
(Your email will be added to Chiromedica's database - we will not sell or give away your info)

Emergency Contact_____ Telephone (____
)_____

Employer _____Telephone (____
)_____

Type of Injury / Condition _____Onset / Injury Date
_____

Have you consulted another doctor / practitioner for this health concern? Y / N

If yes, name _____date_____

Are your health concerns: ☐ Improving ☐ Getting Worse ☐ Staying the Same

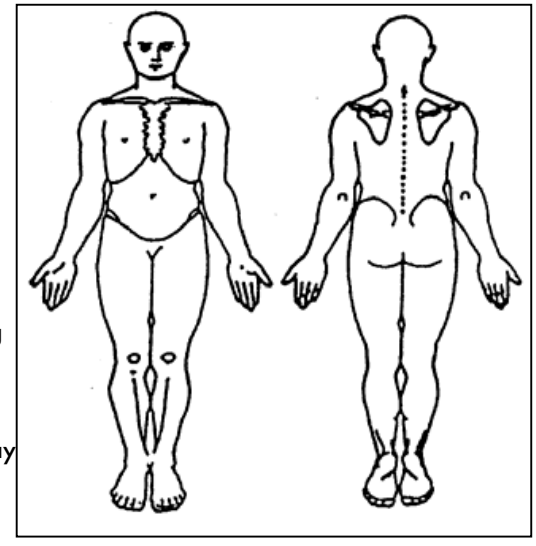
Is your pain...☐burning ☐dull ☐shooting ☐aching ☐throbbing

When do you feel your pain...☐constantly ☐frequently ☐occasionally

Are your symptoms are affected by...☐standing ☐sitting ☐bending ☐walking
☐lying down ☐weather

Do your symptoms interfere with...☐work ☐day-to-day activities ☐sleep ☐play

On a scale of 1-10 (1= least, 10 = most) please rate the severity of your symptoms.



1 2 3 4 5 6 7 8 9 10 **Mark Area(s) of Concern**

INSURANCE PATIENTS ONLY

Primary Insurance_____ Telephone (____)_____

Insured Name _____Subscriber's ID#_____D.O.B._____

Please note that you are financially responsible for any charges not covered by your insurance plan.

Patient Signature _____ **Date** _____

(Parent/Guardian, if patient is a minor)

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NOTIFICATION

HIPAA

Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Chiromedica is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice on paper.

If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below. If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it.

Acknowledgement

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

- OR -

Waiver

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and I have declined such Notice. I am aware that this Notice is available to me from Chiromedica at any time. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____

. *CHIROMEDICA*

Chiropractic Clinic

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have

the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

PATIENT SIGNATURE:	DATE:

(Or Patient Guardian/Parent/Representative – provide name and relationship if signing for patient)