Broadway Chiropractic

Charging toward health

Patient Name:_____
Last First M.I.

Address:_____ **City:**_____ **State,Zip:**_____

Cell Phone:_____ **Home Phone:**_____

We use texting for appointment reminders. Who is your cell phone provider?_____

Email:_____ **D.O.B.**_____

Sex (Circle one): Male Female **Status (Circle one):** Married Single

Occupation:_____ **Employer:**_____

Who may we thank for referring you?_____

List any past surgeries and dates:_____

List any past accidents and dates:_____

Chiropractic History:

Have you ever been to a Chiropractor before? (Circle one): Yes No

If yes, Doctor's name:_____

Date of last Chiropractic visit:_____ **Date of last Chiropractic X-rays**_____

Reason for care:_____ **How long were you under care?:**_____

Are your other family members under Chiropractic care? (Circle one): Yes No

What is the reason for your visit today?:_____

_____

_____

Please list (if applicable):

Allergies	Medications	Supplements
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle all conditions that you have or have had:

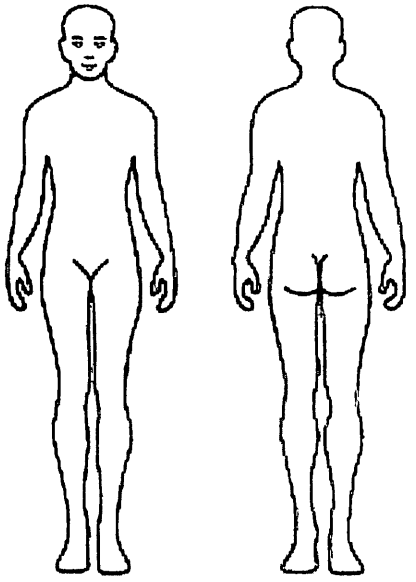
- ☐ AIDS/HIV
- ☐ Anxiety
- ☐ Joint Swelling
- ☐ Nausea
- ☐ Fatigue
- ☐ Insomnia
- ☐ Arthritis
- ☐ Frequent Colds
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Cough
- ☐ Chest Pains
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues
- ☐ Elbow/Wrist/Hand Issues
- ☐ Thyroid Issues
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Cardiovascular Issues
- ☐ Dizziness
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Neck Pain
- ☐ Multiple Sclerosis
- ☐ Lymphatic Issues
- ☐ Immune Issues
- ☐ Skin Conditions
- ☐ Female Problems

How intense are your symptoms? (Circle one):

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — Intense Symptoms

Mark 'X' on the areas below where you have symptoms



What does it feel like? (Circle all that apply):

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Sharp
- ☐ Nagging
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other: _____

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This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. **Please initial** to indicate that you have been made aware of its availability:_____

The statements made on these new patient forms are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____

Guardian Signature_____

Today's Date_____

BROADWAY CHIROPRACTIC
Jeffrey D. Schones, D.C & Todd Spicer, D.C

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 for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The 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: The state of optimal physical, mental and social well being, 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 impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal 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 another health care provider.

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 PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ _____ have read and fully understand the above statements
Printed Name

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

Agreement to Notice of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Broadway Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice (upon request, located at the front desk).

_____
Printed Name

_____ _____
Signature Date

Broadway Chiropractic Office Policies

At our office, we have one simple goal. We want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some business procedures in this office to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions please direct them to the receptionist.

1. Patient history, terms of acceptance, and insurance information (if insured) must be read, signed and presented to the office on your first visit.
2. We ask that while in the adjusting room you refrain from touching your cell phone. If a call is important and you "must" take it, please understand that the doctor will bypass you for the next ready patient so that we do not delay other patients, you will then be the next patient to be seen by the doctor
3. It is required that all patients attend a one time "Report of Findings" health workshop within the first week of care. We have found that the patients who follow this recommendation GET BETTER FASTER AND SPEND LESS MONEY.
4. It is necessary to schedule all appointments in order for us to serve you in a timely manner.
5. Walk-in patients are welcome, but must understand that we first assist those with scheduled appointments.
6. All missed appointments must be made up for you to obtain the best correction in the shortest amount of time.
7. If you are going on vacation, please let us know so we may document your file and avoid calling you unnecessarily.
8. Payment is due at time of service unless prior arrangements have been made.
9. Balances must be kept under $100.00 on a weekly basis, unless otherwise agreed on (i.e. in house care plan).
10. Patients that do not give a 24-hour notice to cancel a massage appointment will be charged a $20.00 fee for each ½-hour appointment missed.
11. As a courtesy to you, our office will submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by our office. Our Office takes *no responsibility* for non-payment by insurance companies for services rendered at our clinic.
12. Personal injury patients must stay consistent with adjustments and notify the office of any changes with adjusters or attorneys.
13. Personal injury patients will be billed through any available med-pay, third party or group insurance policies. If there is no insurance to pursue, the patient must have an attorney representing them and 3 signed liens in file. We would be prefer to provide you with a list of attorneys that we have experience with.
14. Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize release of any information necessary to process my insurance claims via electronic submission, fax or postal. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Print your name _____ Today's Date_____

Sign your name_____

Broadway Chiropractic's Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his 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 cold packs, manual traction and mechanical traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation.

Probability of risks occurring: 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. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
  Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
  Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of crosses.

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.

Unusual Risks: I have had the unusual risks of my particular case explained to me, if applicable

I have read the explanation above the chiropractic care. I have had the opportunity to have any question answered to my satisfaction. I have fully evaluated the risks and benefits of receiving treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent.

_____
Printed Name

_____ _____/_____/_____
Signature (Required) **Date**

(Pregnancy Release for Women only)

Pregnancy Release: This is to certify, to the best of my knowledge, I am not pregnant and the treating doctor has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Initials: _____

Date of last menstrual cycle (if applicable): _____/_____/_____ (***or***) **I am pregnant** ☐