Case History

Name _____ Date _____

Ethnicity _____ Race _____ Language _____

Address _____ City _____ State _____ Zip _____

Cell Phone (____) _____ Cell Carrier _____ Date of Birth _____ Age _____

Referred by _____ Work Phone (____) _____

Occupation _____ Employer _____

Marital Status S M D W Number of Children and Ages _____

Have you ever received Chiropractic Care? Yes ❑ No ❑

Social Security # _____ Email Address _____

Emergency Contact/Phone _____

AS you increased your layers of damage you probably began to experience symptoms and random bouts of sickness. Leave blank if does NOT apply.

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Notes
❑	❑	Were you taught proper body movements and care?		
❑	❑	Did/do you smoke? If so, how much?		
❑	❑	Did/do you drink any alcohol?		
❑	❑	Weight gain or loss?		
❑	❑	Have you been in any accidents?		
❑	❑	Allergies: Food/Drug/Environmental?		
❑	❑	Teeth problems?		
❑	❑	Eye problems?		
❑	❑	Hearing problems?		
❑	❑	Exercise regularly?		
❑	❑	Loss of sleep?		
❑	❑	Did/do you have occupational stress?		
❑	❑	Physical stress?		
❑	❑	Mental stress?		
❑	❑	Hobbies/Sports injuries?		
❑	❑	Other traumas or problems?		
		Sleep posture: ❑ Side ❑ Stomach ❑ Back		

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint (be specific)

Major complaint _____

_____

_____

Pain or problem started on _____

Pains are: ❑ Sharp ❑ Dull ❑ Constant ❑ Intermittent

On a scale of 1 to 10, what is your pain level? _____

What activities aggravate your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Have you seen other doctors for this condition? _____

Any home remedies used? _____

Other symptoms: **O** - Occasional, **F** - Frequent, **C** - Constant. **Leave blank if does NOT apply.**

O	F	C		O	F	C		O	F	C	
❑	❑	❑	Headaches/Migraines	❑	❑	❑	Arm pain L - R	❑	❑	❑	Stomach upset
❑	❑	❑	Neck pain	❑	❑	❑	Elbow pain L - R	❑	❑	❑	Constipation
❑	❑	❑	Neck stiff	❑	❑	❑	Shoulder pain L - R	❑	❑	❑	Diarrhea
❑	❑	❑	Mid back pain	❑	❑	❑	Muscle tension-neck	❑	❑	❑	Acid reflux
❑	❑	❑	Mid back stiff	❑	❑	❑	Muscle tension-mid back	❑	❑	❑	Bowel control
❑	❑	❑	Low back pain	❑	❑	❑	Muscle tension-low back	❑	❑	❑	Bladder control
❑	❑	❑	Low back stiff	❑	❑	❑	Dizziness	❑	❑	❑	Loss of smell
❑	❑	❑	Pins & needles in legs	❑	❑	❑	Ears ring or buzz	❑	❑	❑	Loss of taste
❑	❑	❑	Pins & needles in arms	❑	❑	❑	Light bothers eyes	❑	❑	❑	Hands cold
❑	❑	❑	Numbness in toes	❑	❑	❑	Fatigue	❑	❑	❑	Feet cold
❑	❑	❑	Numbness in fingers	❑	❑	❑	Depression	❑	❑	❑	Cold sweats
❑	❑	❑	Sciatica L - R	❑	❑	❑	Loss of balance	❑	❑	❑	Other _____

List of vitamins and herbal support _____

_____

Have you been under medical care? _____

What medications are you taking? _____

_____

_____

_____

List all surgeries and date of surgery: _____

_____

_____

What side effects have you experienced from the drugs and surgery? _____

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	❑	❑	❑	❑	❑
Mother's side	❑	❑	❑	❑	❑

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care which corrects the most recent layer of spinal and neurological damage (VSC.) This care usually reduces or eliminates the symptoms. Then begins Reconstructive Care which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay a percentage of services or co-pay as they are rendered in accordance with my insurance policy. However, I understand I am ultimately responsible for the full amount of payment for services rendered.

Signature of patient or guardian _____

Consent to treat a minor _____

Signature of person responsible for payment _____

Date _____

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is call informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device of machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type adjustment on patients.

Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Two other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury and spina dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that ther are no available statistics to quantify their incidence.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to urinate or to start a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc. may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their incidence. Never put a home ice pack directly on the skin, always have an insulating towel between the ice pack and the skin.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have full understanding, please sign and date below.

_____ _____

Patient name (printed) Today's date

_____

Patient's signature or Guardian's signature for a minor

Back to Health Chiropractic financial Policy

Non-covered services– Your insurance is an agreement between you and your insurance company. It is not an agreement between your insurance company and this office. The cash price for an adjustment is $50. If, for some reason, your insurance does not pay for your services, you will be responsible for payment and will receive a bill for the balance due. This applies to any insurance you may have, including Medicare and Medicaid.

Co-pays and Co-insurance- All copays, co-insurance, and deductible payments are due at the time of service.

Cancellations- This clinic requires a 24-hour notice of cancellations. We ask that you respect our time, and the needs of other patients by adhering to this cancellation policy. Any last-minute cancellations or no-shows will be charged a mandatory fee of $25. After 3 no-shows, we reserve the right to not schedule any more appointments for you. This cancellation policy applies to any missed appointments including, but not limited to massage and stretch appointments.

Non-payment- Please be advised that if your account remains past due for more than 90 days, we will refer your account to a collection agency, and you will be responsible for all fees associated with the collections process.

I fully understand and agree that should my account become 60 days past due, a 2% monthly account administrative late charge will be added to my account balance each month until my balance is brought current.

Print Name _____ **Signature** _____ **Date** _____

Rogers Back To Health Chiropractic

HIPAA Privacy Policy and Patient Consent Form

Our Promise to You our Valued Patient: We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy? The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer this data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment: Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment: Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations: Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Patient Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email (unless you tell us that you prefer not to receive reminders).

Public Health and National Security: As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers: We may share your health information with those you tell us will be assisting you with your home care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research: Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information: Other than what is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient's Rights: This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications: You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information: You have the right to read, review and copy your health information including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your Health Information: You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information: You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. We are required by law to maintain the privacy of your health information, and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information. Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____

PRINT PATIENT NAME DATE

_____

PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE

_____

PRINT NAME OF REPRESENTATIVE RELATIONSHIP TO PATIENT

I acknowledge that I do not wish to obtain a copy of the HIPAA Privacy Policy.

_____

PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE