PLEASE PRINT SINGLE SIDED!

You will have four (4) pages to bring in. This page does not need to be included.

INSTRUCTIONS FOR FILLING FORMS

The first page is personal information. As much of this page as you are comfortable writing down, we would greatly appreciate it! We are working on being able to send appointment reminders, special opening and closing times, and other such notifications, so if you would like to be included in those, we will require an [email address] or [cell number and carrier] to include you in the notifications. Any information on the following lines could be used for certain situations. For social security numbers, we will need those if you ever have to hold a balance; otherwise, you would have to pay your fee after every visit. Employment information, spouse information, and nearest relative information is used in the event of something happening to you while you are in our office. The last paragraph is our shortened privacy policy, or HIPAA. Basically, it states that we will never give any of this information to unrelated third parties, and it will all be stored as securely as we are able. You will need to print your name in the "Patient Name" section, sign, and date beside the bolded X's.

The second page is your health history. It will help Dr. Schneider to focus on the areas actually giving you issues if you fill out as much as you are able, especially the particular reasons you are consulting our office. For example, you can list neck, upper back, mid back, or lower back pain, as well as extremity pain, headaches, constipation, and so on. The paragraph at the bottom is on the authorization of our office being allowed to bill insurance and such, and that you are willing to pay whatever you owe for any services we give. Again, you will need to print your name, sign, and date beside the bolded X's.

The third page is the x-ray assignment agreement, which basically states that Dr. Schneider will want to take some x-rays for the exam during your new patient appointment. If he finds anything supremely unusual or concerning on them, he may want to send them out to a radiologist and get a second opinion from another professional. This form gives us permission to send the x-rays out. Once again, you will need to print your name, sign, and date beside the bolded X's. You will not need to fill out either the top section or the bottom section at all.

The last page is our informed consent form. It goes over all the benefits and risks associated with chiropractic care. You may read it over, and will need to print your name, sign, and date beside the bolded X's one final time.

Thank you very much!

ARBOR CROSSING CHIROPRACTIC LIFE CENTER
Dr. Grant Schneider

PERSONAL INFORMATION

Today's date:_________________

Name: Last________________________ First__________________________ Middle___________________

Address_________________________________ City____________________ State________ Zip_________

Birthdate: _______________________ Sex: M ☐ F ☐ Married?______________ Single?____

Phone:_______________________ Phone Carrier:____________________ May we contact you through:

Email:____ Text ☐ Email ☐

Social Security #:__________________________ Driver's License #:_________________________________

Employed by:__________________________________ Occupation:_________________________________

Work Address:_______________________________ City:_____________ State:________ Zip:_________

Work phone #:_______________________ ext:________

Spouse's Name:__________________________________ Spouse's Birthdate:_________________________

Nearest relative:__________________________ Their phone #:__________________ Carrier: ____________

Acknowledgment of Receipt of Notice of Privacy Policy

I acknowledge that **Arbor Crossing Chiropractic Life Center's** "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review **Arbor Crossing Chiropractic Life Center'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 **Arbor Crossing Chiropractic Life Center**. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practices for **Arbor Crossing Chiropractic Life Center** is also provided on request at the main administration desk of this practice.

Arbor Crossing Chiropractic Life Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling **Arbor Crossing Chiropractic Life Center** the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name: X______________________ Signature: X____________________ Date: X__________________

Parent or Guardian: ____________________ Signature: ______________________ Date: ____________________

REASON FOR CONSULTING OFFICE

List all health problems or symptoms you wish to consult with the doctor about today.____________________________

____

HEALTH INSURANCE (check all that apply) (if more than one, note primary and secondary)

Blue Cross_____ Medicare______ Medicaid______ Other______ → Name____________________ None____

***Please **CIRCLE ONE** if your condition is **THE DIRECT RESULT** of an **AUTO ACCIDENT**, an **ON THE JOB INJURY**, or **OF ANOTHER PARTY'S NEGLIGENCE,** please ask the front desk person for an additional form.

HEALTH HISTORY

List **ALL** past surgeries and year performed:____

____

List **ALL** health problems you have had:____

____

Do you smoke or use tobacco? Yes ☐ No ☐

Are you now, or have you ever been exposed to any chemical or environmental hazards? If yes, describe.

____

Have you ever been diagnosed or treated for any form of cancer? If yes, describe and include dates. _________________

____

List any broken bones and year occurred: ____

If female, are you pregnant at this time? Yes ☐ No ☐ Not sure ☐

PRIMARY CARE PHYSICIAN

Name:___________________________ Address:____

Phone:___________________________

AUTHORIZATION, ASSIGNMENT, AND FINANCIAL RESPONSIBILITY:

Dr. Grant Schneider, D.C., in consideration of your undertaking to treat me:
I authorize you 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 as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I understand that regardless of my insurance status, I am ultimately responsible for all of my debts resulting from my care at ARBOR CROSSING CHIROPRACTIC LIFE CENTER. Should I fail to pay for services rendered, my account may be turned over to a collection agency or attorney for collection. Once my account is turned over to a collection agency or attorney, I shall be responsible for the full balance due, plus an additional 35% of the current balance due to cover collection costs and/or attorney fees. I hereby consent to receive autodialed and/or pre-recorded calls from or on behalf of ARBOR CROSSING CHIROPRACTIC LIFE CENTER at the telephone number provided above by third parties and they may be retained by your office in connection with my account.

Patient Name: X______________________ Signature: X____________________ Date: X________________

Parent or Guardian: _____________________ Signature: _______________________ Date: _____________________

ADVANTAGE RADIOLOGY SERVICE

F: (419) 269-2164   P: (844) 283-4163

PATIENT ____________________ **CLINIC** ____________ **FILM DATE** __________

AGE _____ **SEX M ☐ F ☐ SOCIAL SECURITY #** ____/____/____ **DATE OF BIRTH** __________

PATIENT ADDRESS____________________ **CITY**____________ **STATE**_____ **ZIP**_____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to ensure the highest quality interpretation of my x-rays. I acknowledge that these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury. I hereby authorize the use of electronic transmission of records.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

Patient Name: X____________ Signature: X____________ Date: X____________

Parent or Guardian: ____________ Signature: ____________ Date: ____________

PATIENT HISTORY

PATIENT PRESENTATION ____

____

TRAUMA? YES ☐ NO ☐ EXPLAIN ____

PAST MEDICAL HISTORY ____

____

MALIGNANCY? YES ☐ NO ☐ DETAILS____

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE]____________________

____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves our understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by tear in the inner layer of the artery that may cause the development of thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in normal, healthy arteries. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The report association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. There options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course or care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: X____________________ Signature: X____________________ Date: X__________________

Parent or Guardian: ____________________ Signature: ____________________ Date: __________________