Welcome to Willows Chiropractic Clinic

PLEASE PRINT CLEARLY:

PERSONAL:

Patient Name ________________________________ Email: ____________________________
Street Address ____________________________________ Phone _______________________
City ______________________State _____ Zip __________ Cell Phone: _________________________
Date of Birth__________________ Age: ________ Social Security #: ________________

Best time and place to reach you? _________________________

Spouse's Name: ______________________________ Date of Birth: ______________
Occupation: _______________________ Employer: __________________________________
Social Security #: ___________________

Whom may we thank for referring you or how did you hear about our clinic?_______________________

IN CASE OF EMERGENCY, CONTACT:

Name: ______________________ Relationship to Patient: __________ Phone Number: __________

EMPLOYMENT:

Employer: _________________________________ Occupation: _________________________

Employer Street Address: ________________________________ Phone: ___________________

City / State / Zip : ________________________________

Please Check: **Sex**: Male [ ] Female [ ] **Marital Status**: Married [ ] Single [ ] Divorced [ ]

INSURANCE:

Who is responsible for this account?__________________ Relationship to Patient?: _______________

Insurance Carrier: ______________________________ Subscriber: _______________________

Relationship to patient? _________________ Subscriber I.D.#: _____________ Group #:_________

Is patient covered by additional insurance [ ] YES [ ] NO

Insurance Carrier: ______________________________ Subscriber: _______________________

Relationship to patient? _________________ Subscriber I.D.#: _____________ Group #:_________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage through the carrier(s) listed above and assign directly to Frank J. Door, D.C., C.C.S.P. and / or Willows Chiropractic Clinic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X___________________________________ ______________________ ____________
Responsible Party Signature Relationship to Patient Date

HEALTH HISTORY:

Give reason for seeking chiropractic care: ____

When did your symptoms appear? ____________________ Is condition due to an accident: [ ] YES [ ] NO

Date of Injury or Accident: ___________ Type of Injury: [ ] Auto [ ] Work [ ] Home

To whom have you made a report of your accident? [ ] Auto Insurance [ ] Employer [ ] Worker Comp.

Have you consulted an attorney? [ ] YES [ ] NO Attorney name _______________ Phone: __________

Is this condition getting progressively worse? [ ] YES [ ] NO [ ] UNKNOWN

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _________________________

Describe any health problems, including how long you've had them:

____

____

Are you under the care of any other doctor? Yes_ No__ If yes, Whom? ______________________________

If Yes, the conditions being treated for: ____

List any current Medications:

____

List any past surgeries & dates:____

List any past accidents & dates: ____

List any x-rays you've had in the past 2 years: ____

CHIROPRACTIC HISTORY:

Have you ever been to a Chiropractor before? YES [ ] NO [ ]

If yes, Doctor's Name_______________________

Date of last chiropractic visit ________________ Reason for care _________________________________

Date of last chiropractic x-rays_______________ How long were you under care? ____________________

Are other family members under chiropractic care? Yes [ ] No [ ] Who? ____________________________

FEMALES: ***Please Check One:*** Is there a possibility of you being pregnant? **YES** [ ] **NO** [ ]

Patient Name: ______________________________ Date: ______________________

List your Pains / Complaints from Most Severe (1) to Least (4) - please circle your response

	1	2	3	4
Today you have the following physical complaints:				
Is this compalint: Sharp, Dull, Achy, Throbbing, Nubm, Shooting or Other (explain)?	Sharp Dull Achy Trhobbing Numb Electric/Shooting Other: ________	Sharp Dull Achy Trhobbing Numb Electric/Shooting Other: ________	Sharp Dull Achy Trhobbing Numb Electric/Shooting Other: ________	Sharp Dull Achy Trhobbing Numb Electric/Shooting Other: ________
How often do you feel this Complaint? Constant, Daily, "Off & On", weekly?	Off & On Weekly Monthly Other ________	Off & On Weekly Monthly Other ________	Off & On Weekly Monthly Other ________	Off & On Weekly Monthly Other ________
How long have you had this?				
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better?				
What makes it worse?				
On a scale of 1 - 10 rate your discomfort:	________ 10 = Excruciating 0 = No Discomfort	________ 10 = Excruciating 0 = No Discomfort	________ 10 = Excruciating 0 = No Discomfort	________ 10 = Excruciating 0 = No Discomfort
How have you taken care of this in the past? How as it worked for you?				
This issue is affecting my: (Circle all that apply)	Job Childcare Marriage Sex Golf Finances Playing with kids Bowels Urine	Job Childcare Marriage Sex Golf Finances Playing with kids Bowels Urine	Job Childcare Marriage Sex Golf Finances Playing with kids Bowels Urine	Job Childcare Marriage Sex Golf Finances Playing with kids Bowels Urine
Helping this issue would increasemy qualifty of life by:	10 - 20% 30 - 40% 50 - 60% 70 - 80% 90% 100%	10 - 20% 30 - 40% 50 - 60% 70 - 80% 90% 100%	10 - 20% 30 - 40% 50 - 60% 70 - 80% 90% 100%	10 - 20% 30 - 40% 50 - 60% 70 - 80% 90% 100%

Patient Name:__________________ **Date:**______________

Please take several minutes to answer these questions so the Doctor can help you get better faster.

1. How have you taken care of your health in the past?

a. Medications	d. exercise	g. vitamins
b. emerg room	e. nutrition/diet	h. chiropractic
c. routine medical	f. holistic care	other _____________

2. How did that work out for you?

a. bad results	d. nothing changed	g. still trying
b. some results	e. didn't get worse	h. confused
c. great results	f. didn't work too long	other_____________

3. How have others been affected by your health condition?

a. no one is affected	c. they tell me to do something
b. haven't noticed any problem	d. people avoid me

4. What are you afraid this might be (or beginning) to affect? (or will affect)

a. Job	d. marriage	g. time
b. Kids	e. self esteem	h. finances
c. future ability	f. sleep	i. freedom

5. Are there health conditions your afraid this might turn into?

a. family health problems	d. diabetes	g. depression
b. heart disease	e. arthritis	h. chronic fatigue
c. cancer	f. fibromyalgia	i. Need surgery

How has this affected your job, relationships, finances, or family, other activities? Give 3 examples

____

____

____

What has that cost you?(time, money, happiness, freedom, sleep, promotion, etc) Give 3 examples

____

____

____

What are you most concerned with regarding your problem?______________________

____

Where do you picture yourself being in 1-2 years if problem isn't taken care of? Be specific______

____

____

What would be different / better without this problem? Be specific__________________

____

____

What do you desire most to get from working with us?______________________

____

____

What's that worth to you? ______________________________

WILLOWS CHIROPRACTIC CLINIC
INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his / her own symptoms and should secure other opinions if he / she has any concern as to the nature of his / her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustment, or health care, if he / she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he / she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling diseases.

TO THE PATIENT

Please discuss any questions or concerns with the doctor **before** signing this consent form. I have read and understand the foregoing.

X____ ____________________

Signature of Patient **Date**

Willows Chiropractic Clinic
HIPAA Communication Requests

Patient Name: ____________________________________

I wish to be contacted in the following manner (check all that apply):
You MUST select one verbal and one written form of communication.

[ ] Home Telephone #: ( ) ___________
- **[ ] O.K. to leave detailed message**
- **[ ] Leave message with call-back name and number only**
- **[ ] DO NOT CALL HOME**

[ ] Work Telephone #: ( ) ___________
- **[ ] O.K. to leave detailed message**
- **[ ] Leave message with call-back name and number only**
- **[ ] DO NOT CALL WORK**

[ ] Written Communication
- **[ ] O.K. to mail to my home address**
- **[ ] O.K. to mail to my work/office address**
- **[ ] O.K. to fax to this #: ( ) ___________**
- **[ ] DO NOT MAIL TO HOME**

[ ] Cellular Telephone #: ( ) ____________
- **[ ] O.K. to leave detailed message**
- **[ ] Leave message with call-back name and number only**
- **[ ] DO NOT CALL CELL**

E-Mail Address: _____________________________________

[ ] Other: ____

____

[ ] I authorize release of my patient billing account information to: _____________________________

Relationship to patient: ____________________________________ Expires: ________________

[ ] I authorize release of my appointment information to: _____________________________________

Relationship to patient: ____________________________________ Expires: ________________

****This office CAN NOT release your account balance, or your appointment date or time to anyone but you unless they are specifically listed on this form or present a valid release of information signed by you.**

I understand that I have the right to request changes to this communication request form. Any changes must be made in writing and a new form completed. This form remains in effect unless written notice is given by me.

I certify that I have received a copy of Willows Chiropractic Clinic's Notice of Privacy Practices.

X____ ____________________ ________________

Patient Signature **[ ] Guardian Signature [ ]** **Patient Date of Birth** **Date Signed**

WILLOWS CHIROPRACTIC CLINIC
FINANCIAL POLICY

Below are the financial polices for our office. Please initial the box next to the policy that you wish to use. Please be sure to read the policy carefully and make sure that you understand and agree to the policy prior to signing this document. Our staff will be happy to answer any questions you may have.

[ ] **NO HEALTH INSURANCE:** Payment is expected at the time services are rendered. For your convenience our office accepts VISA / MASTERCARD, checks and cash. Interest of 1% per month will be added to accounts after 30 days.

[ ] **HEALTH INSURANCE:** Since every health insurance policy is different, we do not know if your insurance policy will cover chiropractic care. Our staff is happy to verify your chiropractic benefits for you. However, it is imperative that you understand that we will be relaying to you the ***quote of benefits received from your carrier and that final payment determinations are made once the claim is received.*** Due to the variance from one policy to another, if we are unable to verify your coverage at the time of your visit, we will require each patient who files insurance through this office to pay the cost of the adjustment plus 20% of any necessary x-rays and examination on their initial visit. Chiropractic coverage will be verified through your insurance company on the next business day. If we have collected more than required by your plan, a refund will be issued immediately or you may opt to apply the credit to future visits. If the patient responsibility exceeds what we have collected, or your plan does not cover chiropractic care, you will be responsible for payment in full upon your next visit. If we are able to verify your coverage at the time of your visit, you will be required to pay any co-pay / co-insurance / deductible portion obtained from your insurance carrier as services are rendered. Interest of 1% will be added to patient account balances after 30 days.

[ ] **WORKER'S COMPENSATION:** All on the job injuries ***MUST BE REPORTED TO YOUR EMPLOYER AND A CLAIM MUST BE FILED*** with the Department of Labor & Industries, or your employer's self insured firm. If you were injured on the job you will need to provide our office with a copy of your accident report form. If you have not completed an accident report form, please advise us and we will assist you in filing your claim. It is imperative that you understand that the treatment you receive in this office must be a direct result of the injury incurred on the job. If the treatment can not be substantiated, you will be responsible for the payment of your services. If your claim is not allowed by Labor and Industries you will be responsible for the payment of the services received in our office. In the event that treatment can not be substantiated or your claim is denied by Labor and Industries, your financial policy will revert to the Health Insurance or No Health Insurance policy listed above.

[ ] **MEDICARE:** Medicare does cover medically necessary chiropractic care to correct a subluxation of the spine. However, the initial examination and any x-ray determined necessary by your Chiropractor are not covered by medicare and will be your responsibility. Payment for these services is expected at the time services are rendered. Medicare does not cover maintenance care or care that does not meet Medicare's definition of medical necessity. Each visit the Doctor will advise you as to the approximate cost of the visit and his reason, if any, that he believes Medicare may not pay for your services. You will have the option of electing to receive care or not. We are required by law to collect all deductibles and co-pays set forth by Medicare. Interest of 1% will be added to unpaid accounts after 30 days.

Kindly give 24 hour notice of any appointment cancellation. Appointments not cancelled 24 hours prior, or missed appointments, are subject to a $30 No Show Fee that will be your responsibility, insurance carriers do not pay for missed appointments.

*****IF YOU WERE INVOLVED IN A MOTOR VEHICLE ACCIDENT, OR A SLIP AND FALL, PLEASE ADVISE OUR STAFF AND REQUEST THE PERSONAL INJURY FINANCIAL POLICY****

I, the undersigned certify that I (or my dependent) have insurance coverage as listed above and assign directly to Dr. Door all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Door to release all information necessary, including medical records, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X______________________________ ________ ____________________

Signature [ ] **Patient** [ ] **Parent** [ ] **Guardian** Date Witnessed

Please Fill in Below

If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _________	❑	❑

Circle the areas where you have any problems.
Please also describe these problems.

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

____

____

____

____

____

____

____

Thank you for being complete and thorough.

Your Signature Below Please

____

Date: _______________________