CHARGE INTO HEALTH
FAMILY CHIROPRACTIC

Registration Form

(PLEASE PRINT) DATE _____

Last Name _____ First Name _____ Middle Initial ___

Phone (Home) _____ (Cell) _____

Street Address: _____

City _____ State _____ Zip _____

□ Male □ Female Age _____ Date of Birth _____ Occupation _____

Are you: □ Single □ Married □ Divorced □ Separate □ Widowed

Would you like to receive our Charge into Health Newsletter? Email: _____

Who referred you to our office? _____

CONSENT TO INITIATE CARE

At our office we have a simple goal – we want to provide the highest quality CHIROPRACTIC care at the most affordable cost to the patient. In order to accomplish this goal, we have altered some of our business procedures 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 ask us!

- You may choose to 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 this office. We take ***no responsibility*** for non-payment by insurance companies for services rendered in our office
- Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records at any time they request.
- No balances can be kept or run by patients at any time.
- All adjustment visits are paid immediately ***prior*** to the service being rendered.
- All initial visits including exam and thermal scans are paid upon ***completion*** of these services.
- Our office 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 wish to initiate care at this office. I have read and understand the ***Consent to Initiate Care*** and agree to all terms. I understand that I am under no obligation to receive or continue care.

PRINT: _____

SIGN: _____ DATE: _____

Chiropractic Health Questionnaire

1. Research shows that your spine should be checked regularly, beginning at birth. How many times have you visited a chiropractor in your lifetime? _____ □ Never

2. When was your last complete spinal examination including x-rays? _____ □ Never

3. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problems?
□ Yes □ No

4. Spinal misalignments (Subluxations) cause decay and degeneration which result in grinding or cracking. Do you ever hear noises when you move your head or neck? □ Yes □ No

5. Spinal misalignments (Subluxations) can sometimes make you feel like you need to twist, stretch, or crack your neck and or back. Do you ever feel the need to crack or pop your neck or lower spine?
□ Yes □ No

6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

8. Please list any symptoms or health complaints you are experiencing.
1. _____ 2. _____ 3. _____

9. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. They are one of the leading causes of death in this country. What medications are you currently taking? _____
_____

10. Auto and work related injuries can cause spinal problems. Is this visit related to an accident or injury?
□ Yes □ No If yes, Date of Accident: _____

11. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant?
□ Yes □ No

12. If the doctor feels that chiropractic will help you, are you willing to follow his recommendations?
□ Yes □ No

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE, AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient's Signature: _____ Date: _____

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FAMILY CHIROPRACTIC

WORK INJURY AND AUTOMOBILE INJURY NOTICE

By signing below, I acknowledge that I am aware that Charge Into Health Family Chiropractic and Dr. Gail D. Kelley do not provide care for work related injuries, automobile accident injuries, or personal injury of any kind. I also acknowledge that I must inform this office if I am in an automobile accident or have a work related injury and must seek care at a medical doctor's office or another healthcare provider for any injuries or conditions sustained in the above mentioned manners.

I am also completely aware that Charge Into Health Family Chiropractic and Dr. Gail D. Kelley will not bill, submit claims, nor prepare or submit reports for any automobile, personal, or work related injury. I also understand that I am responsible to pay each visit myself at the time of service.

PRINT: _____

SIGN: _____ DATE: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does not diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** or spinal misalignment, in and of itself, is a detriment to life and health. Correction of the Subluxation through a specific chiropractic adjustment allows the body to function at its optimum level.

One of the many benefits of a chiropractic adjustment is that you **MAY** feel better but this is not the **GOAL** of an adjustment. The goal of an adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, **WE DO NOT TREAT PAIN OR DISEASE**; we remove subluxations to allow the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.

WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATION(S).

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENTS RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, _____, having read the above statement, and
PRINT NAME

understanding it fully, do undertake chiropractic health care on this basis.

SIGN: _____ DATE: _____

Dedicated to Quality CHIROPRACTIC Care

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at the time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: _____ Date: _____

Restrictions:

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____ Date: _____