Dear Patient,

You have a right, as a patient, to be informed about your condition and the recommended chiropractic adjustments and other procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to alarm you, it is simply an effort to better inform you so you may give or withhold your consent to the procedure with the appropriate knowledge.

In the practice of chiropractic there are some risks to examination and treatment procedures including, but not limited to; fractures, disc injuries, dislocations, sprains/strains and increased symptoms and pain, or no improvement of the symptoms or pain. A very rare but serious risk associated with neck manipulation is stroke. X-rays may be a part of the examination and the use of x-ray equipment may pose an added risk if you are pregnant.

The Doctor of Chiropractic is not able to anticipate and explain all of the risks and complications, but relies on clinical judgement based on all the facts known at the time of the procedure, and makes decisions that according to the facts available, are to the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatments.

The results of the examination I receive at Westwood Chiropractic will be explained to me. Including the proposed plan of care and the possible risks associated with the treatment. I understand that my care will be rendered by a licensed Doctor of Chiropractic. I also understand the cost of the treatment proposed.

I have read and understand the statements written on this form. I understand that I will have the opportunity to ask the Doctor questions, and my questions will be answered. Based on this information:

❑ I consent to this treatment ❑ I do not consent to this treatment

In signing this statement you are consenting to treatment in this office.

_____ Date of Birth _____ / _____ / _____

Patient's Name (Please Print)

_____ Today's Date _____ / _____ / _____

Patient's Signature

_____ Today's Date _____ / _____ / _____

Signature of Parent of Guardian consenting to treatment for a minor

CONFIDENTIAL PATIENT DATA

Today's Date: _____ / _____ / _____

Patient's Legal Name: _____ Patient's Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (____) ____-_____ Cell :(____) ____-_____ Work Phone: (____) ____-_____

Email Address: _____ Nick Name: _____

Social Security #:_____ - ____- _____ Age: _____ ❑ Male ❑ Female

Marital Status: ❑ Partnered □Married ❑Single ❑Divorced ❑Widowed ❑Other _____

Name of Emergency Contact _____ relation_____ Phone:(____) ____-_____

Your Occupation_____ Your Employer:_____

Referred to this Office by: ❑Friend/Family Member - Name_____

❑Search Engine ❑ Email/ Mail ❑Clinic Location ❑Facebook/Instagram ❑Other_____

Payment for Services will be by: ❑Cash/Check /Credit Card ❑Health Insurance Policy & Cash/Check/Credit

❑Automobile Insurance Policy ❑Worker's Compensation Policy

Name of Insurance Co.:_____ Subscriber/ Primary Ins. Carrier _____

Subscriber's Date of Birth ____ / _____ / _____ Subscriber's Employer: (if different from above) _____

Do you have a secondary insurance policy? ❑No ❑Yes & Name _____

❑Provided Insurance Card & Identification (Please provide these to the office staff to make a copy for your records. Thank you!)

HEALTH HISTORY

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Name & Location of Doctors previously seen for any/all present health conditions Health condition Approximate date last seen

_____

_____

_____

_____

_____

Are you allergic to any medications? □NO □YES & WHAT KIND?_____

Are you taking any medications? □NO □YES & WHAT KIND?_____

Are you Pregnant? □YES □NO □MAYBE First day of your Last Menstrual Period _____ / _____ / _____

Do you have any metal implants? ❑No ❑Yes Describe : _____

Have you ever been shot by a gun? ❑No ❑Yes _____ / _____ / _____

Patient's Name (Please Print)_____

MEDICAL HISTORY

FAMILY MEDICAL HISTORY (Please indicate which conditions have been experienced by you or your parents by marking appropriate boxes)

Father	Mother	Self	Father	Mother	Self	Father	Mother	Self
❑	❑	❑Aids	❑	❑	❑epilepsy	❑	❑	❑multiple sclerosis
❑	❑	❑allergies	❑	❑	❑German measles	❑	❑	❑polio
❑	❑	❑arthritis	❑	❑	❑high blood pressure	❑	❑	❑poor circulation
❑	❑	❑asthma	❑	❑	❑HIV/ARC	❑	❑	❑reproductive disorder
❑	❑	❑bone fracture	❑	❑	❑heart trouble	❑	❑	❑rheumatic fever
❑	❑	❑cancer	❑	❑	❑headaches	❑	❑	❑rheumatism
❑	❑	❑concussion	❑	❑	❑hepatitis	❑	❑	❑scarlet fever
❑	❑	❑convulsions	❑	❑	❑indigestion	❑	❑	❑sinus trouble
❑	❑	❑diabetes	❑	❑	❑kidney disorder	❑	❑	❑ tuberculosis
❑	❑	❑dislocated joints	❑	❑	❑muscular dystrophy			

SURGICAL HISTORY:

1._____Date:_____ /_____/_____

2._____Date:_____ /_____/_____

3._____Date:_____ /_____/_____

4._____Date:_____ /_____/_____

ACCIDENT HISTORY:

1. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

2. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

3. ❑Job ❑Auto ❑Other Date: _____ / _____ / _____

CURRENT COMPLAINTS:

SYMPTOMS DEVELOPED FROM: ☐JOB RELATED INJURY ☐AUTO ACCIDENT ☐OTHER ☐ACCIDENT ☐ILLNESS ☐UNKNOWN CAUSE ☐GRADUAL ONSET

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate your symptoms 1-10 (with 1 being least serious)

❑Headache- Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Neck- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Shoulder- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain /tingling down arm- R / L Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Mid Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Low Back- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Hip- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Pain down Leg- Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other _____ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10
❑Other _____ Left / Right Pain Level: 1 2 3 4 5 6 7 8 9 10

Symptoms Began: _____ / _____ / _____ SYMPTOMS ARE WORSE IN ☐MORNING ☐AFTERNOON ☐NIGHT

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ___DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT ☐ ARE NEARLY CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES & WHEN?_____

Please check the following activities that **AGGRAVATE** your condition: ❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING ❑WORK DUTIES

Please check the following activities that **RELIEVE** your condition:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING ❑CHIROPRACTIC TREATMENT

ADDITIONAL SYMPTOMS you may be experiencing: ❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia (trouble sleeping) ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: _____ Date:_____

FINANCIAL AGREEMENT

I agree that insurance reimbursement is NOT A SUBSTITUTE FOR PAYMENT. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by the insurance company.

IN ORDER TO CONTROL THE PATIENT'S OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE AT THE TIME OF SERVICE.

If the patient's account is assigned to an attorney or outside agency for collection and/or suit, WESTWOOD Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any charges related to my treatment at WESTWOOD Chiropractic.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance or employee health care benefits coverage, and hereby assign and convey directly to WESTWOOD Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered by WESTWOOD and its providers. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize WESTWOOD to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to WESTWOOD any and all plan documents, insurance policy and/or settlement information upon written request from WESTWOOD in order to claim such medical benefits, reimbursement, or applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby authorize WESTWOOD to claim such medical benefits, insurance reimbursement, and any applicable remedies to the full extent permissible by law and under any applicable insurance policies and/or employee health care plan, or other right I may have to insurance and/or employee health benefits coverage, with respect to medical services provided by WESTWOOD. I further agree in response to any reasonable request for cooperation, to cooperate with WESTWOOD in any attempts to pursue a claim, chose in action or right, against my insurers and/or employee health care plan, including if necessary, bringing suit with WESTWOOD against insurers and/or employee health plan in my name but at the expanse of WESTWOOD.

_____ _____ / _____ / 20___

Patient Name (please print) Date

_____ _____

Patient Signature INSURED'S SIGNATURE if patient is a Minor

HIPPA DECLARATION

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI

(b) Under the Privacy Rule, may be required by State law to great greater access or maintain greater restriction on the use or release of your PHI than that which is provided for under federal law

(c) Is required to abide by the terms of the Privacy Notice

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate you for filing a complaint

EFFECTIVE DATE

This Notice is in effect as of 7/26/04

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient name (please print) INSURED'S SIGNATURE if patient is a Minor

_____ _____ / _____ / 20____

Patient Signature Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith EFFORT to Obtain Acknowledgement

Patient's acknowledgement of this notice could not be obtained because:

__Patient refused to sign

__Communication barrier prohibited obtaining acknowledgment

__Emergency circumstances

__Other

Details:

Westwood Chiropractic

Signature of Practice