King Chiropractic Patient Intake and Consent Form

Patient Information

Name: ____ What you prefer to be called: _______________ Today's Date: _____/______/______
Last First Middle Initial

Birthdate: _____/_____/________ Age: ________ M ☐ F ☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Address: ____ City: _______________________________ State: ________ Zip: __________

Phone: _________________________________ Email: ____ SS# ___________________________________

Emergency Contact: ______________________________________ Phone: _______________________________ Relationship to patient :_________________

How did you hear about us? ____

Accident related? N ☐ Work ☐ Auto ☐ Law Firm: ______________________________ Lawyer's name:_____________________________________

Address: ____ Phone: _______________________________________

Describe accident: ____

Payment/Insurance Information

Payment Method: Cash ☐ Insurance ☐ Primary Insurance: _______________Insurance ID#: __________________________ Group#:_________________

Are you the primary policy holder? Y ☐ N ☐ Insured's Name: ____ Insured's DOB: _____/_____/______

Insured's Phone: ____________________Address: ____ Relationship: _____________

Chief Complaint

What brings you in today?____

When did your symptoms begin? 1-7 days ◻ 1-4 weeks ◻ 1-6 months ◻ Greater than 6 months ◻

How did your symptoms begin? Unsure ◻ ____

What seems to help? ____

What makes your symptoms worse? ____

How often do you experience these symptoms? Constant (76-100% of the day) ◻ Frequently (51-75% of the day) ◻
Occasionally (26-50% of the day) ◻ Off and on (0-25% of the day) ◻

What describes the nature of the symptoms? Sharp ◻ Dull ◻ Achy ◻ Burning ◻ Stabbing ◻ Other:______________________

Please rate symptoms for each complaint in order of importance on a scale of 0-10 with 10 being the worst.

____

Do you experience numbness tingling or weakness in your arms and/or legs? No ◻ Yes ◻ Where? ___________________________________

Please describe exactly where your symptoms are located?____

____

King Chiropractic Patient Intake and Consent Form

Medical History (Please list any current or previous conditions you have had including diabetes, arthritis, cancer, heart disease, stroke etc)

____

Surgical History (Please list any and all surgeries that you have had)________________________________

Please list any fractures or other injuries that you have had. ________________________________

Medications and Allergies

Please list any medications or supplements that you are taking:________________________________

Please list any allergies:________________________________

Social History		
Caffeine use: Daily ◻ Weekly ◻ Monthly ◻	Alcohol: No ◻ Yes ◻ ___drinks/day	Tobacco use: No ◻ Yes ◻ ___Pack/day
What do you do for exercise and how often?		
Family History		
Arthritis: Parent ◻ Sibling ◻	Heart Disease: Parent ◻ Sibling ◻	Thyroid: Parent ◻ Sibling ◻
Cancer: Parent ◻ Sibling ◻	Hypertension: Parent ◻ Sibling ◻	Other: ________________________
Diabetes: Parent ◻ Sibling ◻	Stroke: Parent ◻ Sibling ◻	None ◻

Are you currently receiving or have you received other chiropractic or therapy services this calendar year?	Yes ◻ No ◻
Patient Health Information and Privacy policy: This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: 1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHU to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment. 2. The patient has a right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions. 3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. 4. This office is committed to protecting your PHI and meeting its HIPAA obligations: staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. 5. Patient have the right to file a formal complaint with our privacy official about any suspected violations. 6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.	________ Initial
Consent to Professional Treatment The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. In doing so, the patient understands, acknowledges and affirms that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. The patient may refuse treatment at any time.	________ Initial

King Chiropractic Patient Intake and Consent Form

Treatment of minors: If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on premises during any such treatment and waive any claim I may have resulting from failure to do so.	_________ Initial
Liability: I know and agree that King Chiropractic is not responsible for loss or damage to personal valuables.	_________ Initial
Waiver and Release: I hereby release, discharge and acquit King Chiropractic, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician physician or urgent care services.	_________ Initial
Assignment of Benefits and Release of Records The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred. Patient understands fully that in the event their insurance company or financially responsible party does not pay for the services received, they will be financially responsible for payment.	_________ Initial
Financial Obligation and Appointment Policy: The patient accepts full financial responsibility for services rendered by this practice. ***This office reserves the right to charge a $25 fee for missed appointments or appointments canceled without any advanced notification required by this office. Furthermore, this office reserves the right to terminate care if the patient misses/no shows for three consecutive appointments.*** Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred. I hereby assign all benefits directly to King Chiropractic and also authorize release of any medical records necessary to facilitate my treatment to process medical claims, and otherwise permitted or required in the notice of privacy practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.	_________ Initial
I hearby give consent to be treated with laser/photobiomodulation as explained to me by my doctor. I further understand that this service is not covered by insurance and that I will be responsible to make payment of $40 per laser treatment if performed alone or $15 additional to my standard visit.	_________ Initial
Appointment Policy: Three consecutive no shows/missed appointments will result in termination of care.	_________ Initial
Reminder Consent: I authorize King Chiropractic to send a reminder email the day prior to my next appointment.	
I certify that all the information provided by me herein is true and correct. Patient/Parent/Guardian Signature: ______________________________ Witness: _______________________	

King Chiropractic Patient Intake and Consent Form

King Chiropractic – Informed Consent Form

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to one or more of the following procedures:

• Vital Signs	• Basic Neurology	• Orthopedic Testing
• Range of Motion Testing	• Muscle Strength Testing	• Palpation
• Postural and/or Movement Analysis	• Manual Therapies	• Spinal Manipulation

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. More serious risks may include stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization, surgery. If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(Dr. Rhett King)* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient’s Name______________________________Signature of Patient Parent or Guardian (if a minor) _____________________________

Dated: ______________