Confidential Patient Information

First Name: _____ Last Name: _____ DOB: _____

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

( ) _____ - _____ hm ( ) _____ - _____ cell

Email Add: _____ SS#: _____-_____-_____ Marital Status: M S D W

Occupation: _____ Employer: _____ Wk #: ( ) _____-_____

Spouse's Name: _____ # of Children: _____ Do you have Health Insurance? Y N

Whom may we thank for referring you to our office? _____

Have you ever had Chiropractic Care before? _____Yes _____No Date: _____

Is this injury/illness related to: Auto Accident _____Yes _____No Date of Accident: _____

Your Auto Ins. Co: _____ Phone: ( ) _____-_____ ext: _____

3rd Party Auto Ins: _____ Phone: ( ) _____-_____ ext: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

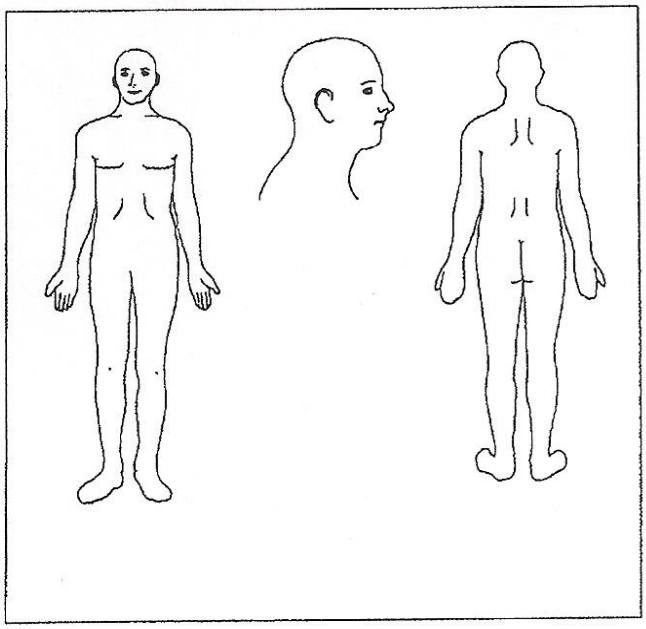
Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting.

I authorize Corrective Care Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the last six months.

( )	Headaches	( )	Sinus Congestion / Allergies	( )	Vision Problems
( )	Ear Aches	( )	Dizziness	( )	Heart Problems
( )	Lung Problems	( )	Blood Pressure Problems	( )	Ankle Swelling
( )	Prostate Problems	( )	Sexual Dysfunction	( )	Menstrual Cycle Dysfunction
( )	Abdominal Cramps	( )	Frequent Nausea / Vomiting	( )	Weakness
( )	Constipation	( )	Diarrhea	( )	Poor / Excessive Appetite
( )	Excessive Thirst	( )	Painful / Excessive Urine	( )	Discolored Urine
( )	Numbness/Tingling into shoulders/ arms/hands			( )	Numbness/tingling in your legs/feet
( )	Pain/weakness into shoulders/arms/hands			( )	Pain/weakness into hips/legs/feet
( )	Cancer	( )	Diabetes		

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

INSURANCE – Until we have the completed, necessary ins information to verify chiropractic coverage, you will be expected to pay at the time of service for your care. Ins companies are required to remit payment (or denial) within 30 days. **In the event you receive the insurance check, it is expected you will present the check to our office**. We will have contacted your carrier for benefits in advance and your financial arrangements will be contingent on your individual coverage and your chiropractic care plan. If your yearly deductible has not been met and any services not covered by your ins and/or denied by your ins or if your coverage becomes inactive or you have met your benefit maximum, all fees will be your responsibility.

Signature: _____ Date: _____

HEALTH CONDITIONS

Name: _____ Date: _____

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down you spine weakening the entire body). Please check any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):
Postural distortion from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience…?

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
  Explain: _____
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent Colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):
Postural distortion from subluxations, (causing Forward Head Syndrome), in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ☐ Heart Palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/ Angina
- ☐ Recurrent lung infections/ Bronchitis
- ☐ Asthma/ Wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

THORACIC SPINE (MID BACK):
Postural distortion from subluxations, (causing Forward Head Syndrome), in the mid back will weaken the nerves into your ribs, chest, and upper digestive tract, and affect these parts of your body. Do you experience…?

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):
Postural distortion from subluxations, (causing Forward Head Syndrome), in the low back will weaken the nerves into your legs, feet, and pelvic organs and affect these parts of your body. Do you experience…?

- ☐ Low Back Pain
- ☐ Pain into your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Sexual dysfunction
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urination
- ☐ Constipation/ Diarrhea
- ☐ Menstrual irregularities/ Cramping (females)

Please list any health conditions not mentioned _____

_____

Please list any medications/surgeries _____

Corrective Care Chiropractic
Privacy Notice

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
We may need to disclose your health information within our practice for quality control or other operational purposes.

You have a right to review our privacy policies in detail or prior to signing this form. A copy is available at the offices of Corrective Care Chiropractic. We reserve the right to change our privacy as described in that notice.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restriction, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you are required to give your authorization as a condition of obtaining your insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form.

_____
Printed Name

_____ _____
Signature Date

Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious political beliefs, quality health care services delivered with dignity and concern.

Corrective Care Chiropractic
801 Hughes Dr. Hamilton NJ

We have put together the following checklist to help our patients determine their responsibility toward payment for chiropractic services. Please initial the statement that best applies to you and sign at the bottom.

_____**MEDICARE:** I am eligible for Medicare. I understand that it only pays for adjustments to the spine; they will not pay for EXAM or X-RAYS. I also understand that Corrective Care Chiropractic will courtesy bill Medicare for me. I am responsible for paying for my services whether Medicare pays or denies my claims.

_____PRIVATE PAY: I agree to assume all responsibility and agree to keeping my account current as laid out in the financial agreement made for payment that is suitable for all parties.

_____**INSURANCE COVERAGE**: I understand that you will be billing my insurance. If for any reason my insurance fails to reimburse for chiropractic care I am therefore responsible for the visits/care I have received.

_____AUTOMOBILE ACCIDENT: I understand if I have med pay on my auto policy, you will bill my auto insurance, and any other party that is involved.

IF I DO NOT HAVE MED PAY, I understand that you will NOT bill my insurance and an other parties involved, unless my case is accepted by a qualified attorney in which case you will send any reports and medical bills to them. I understand I am responsible for any unpaid balance and if my case has not been settled 1 year from my release date I will pay my balance in full or make financial arrangements to clear the balance. I will notify you in the event that I change attorneys.
If neither of these apply, I will be provided with a super bill upon request, to submit to my insurance to be reimbursed.

_____PERSONAL INJURY: Fall, slippage, etc. I understand that I am responsible for the total bill. I understand that you will bill all insurance companies involved.

Please Initial the statement above that best applies and then sign below

_____SIGNATURE_____.

In the event where I _____SIGNATURE_____ Date_____ fail to accept responsibility to pay my portion of my bills and a collection agency needs to hired on behalf of Corrective Care Chiropractic LLC to collect for my overdue balance. I understand I am at fault and I will be charged for such services and agree to pay for these services and that these service bills will be added to my total balance that will be collected because they needed to be involved to recover my finances to pay my bills owed to Corrective Care Chiropractic LLC.

Corrective Care Chiropractic
for children and adults

"OUR MISSION IS TO PROVIDE EXCELLENT HEALTH CARE,
SERVING BOTH CHILDREN AND ADULTS
IN ORDER TO BRING THEM TO A PLACE OF ABUNDANT HEALTH"

Cancellation Policy/No Show Policy

Cancellation Policy/No Show Policy For Doctor Appointments.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a seventy dollar ($70) fee; this will not be covered by your insurance company.

_____	_____	____/____/____
Print Name	Signature Patient/Guardian	Date

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

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.

The goal of the chiropractor

The goal of a chiropractor is to treat a spinal subluxation which is a misalignment of the bones in your spine or extremity. A spinal subluxation can contribute to the following conditions: pain, sciatica, radiating symptoms, numbness/tingling, disc issues, dizziness, headaches, migraines, dizziness, weakness and many more.

Analysis / Examination / Treatment

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

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	electrical stim
ultrasound	hot/cold therapy	massage therapy
radiographic studies	mechanical traction	
therapeutic exercises		

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: muscle strain, cervical myelopathy, costovertebral strains, disc injuries. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck which is extremely rare and the evidence of such is controversial. Some patients may feel stiffness and/or soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for any 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 chiropractor is trained to specifically correct spinal subluxation complexes which may be directly/indirectly contributing to your current condition)

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
- Spinal Injections/Injections
- Physical Therapy

The risks and dangers attendant to remaining untreated

Remaining untreated may allow certain conditions to worsen. Remaining untreated may also allow the formation of adhesions and reduction of mobility which may set up a pain reaction that further reduces mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

PLEASE SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment and risks. By signing below I hereby give my consent to treatment.

Dated: _____

_____ **_Chris Peterson DC_____**
Patient's Name **Doctor's Name**

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)