**Valley Center Chiropractic**
**Patient Introduction Form and Health History**

Full legal name: _____ D.O.B:__/__/__ Sex: M F

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone: (H)_____ (C)_____ (W)_____

Email:_____ Social Security:_____-_____-_____

Marital Status: (Circle one) S M W D Name of Spouse: (if married)_____

Your Place of Employment:_____ Your Occupation:_____

Number and age of children:_____

Name of nearest relative not living with you (in case of emergency):_____

Phone:_____

How did you hear about us or who referred you to us? _____

**Current Health**

What symptoms are you currently experiencing? _____

_____

When did the problem begin? _____

How did it begin? (Check one) Auto Accident ___ Work Related ___ Other___ (if other, please describe) _____

What doctors have you seen for this problem?_____

Have you lost work due to this problem? (If yes, give dates) _____

Have you had and surgeries or been hospitalized for this or any other condition? _____

_____

Primary Care Physician? _____ City:_____

Have you had chiropractic care for this or any other conditions? (if yes, please describe) _____

_____

Are you pregnant?____ Date of last menstrual cycle:_____ Date of last physician visit:_____

**Valley Center Chiropractic**
**Patient Introduction Form and Health History**

**Personal and Social History**

Please list any allergies:_____

Please list all medication(s) you are taking (including over the counter remedies or birth control):_____

Please list any fractures of dislocations:_____

Have you been diagnosed as having or suffering from: (Please check all that apply to you)

__Broken or fracture bones
__Circulatory problems
__Rheumatoid arthritis
__Seizures/convulsions
__A congenital disease
__Excessive bleeding
__Ulcers
__Tumors
__Osteoarthritis
__Epilepsy
__Pacemaker
__Strokes
__Cancer
__Ruptures
__Coughing blood
__Other:_____
__Eating disorder
__Alcoholism
__Drug addiction
__HIV positive
__Gall bladder
__Depression
__High/Low blood pressure

Do you drink alcoholic beverages?____ Do you smoke?____ Do you take vitamin supplements?____

Do you exercise?_____ If yes, frequency and type of exercise:_____

Do you have a history of stoke or hypertension?_____

Please list any other health problems you have, no matter how insignificant they may seem:_____

_____

**Family History**

Parents:

Father: living__ deceased__ (check one) Current age if still living:____ Cause of death and age if deceased:_____

Mother: living__ deceased__ (check one) Current age if still living:____ Cause of death and age if deceased:_____

___Birth parents of family history unknown; (check if applicable to you)

Family diseases (if applicable, indicate whether family member is Father, Mother, Sister, Brother):
TB_____ Cancer_____ Mental Illness_____ Diabetes_____ Lung Disease_____
Asthma_____ Heart disease_____ Stroke_____ Kidney disease_____ Arthritis_____
Liver disease_____ Other_____

Signature of Patient or Legal Guardian:_____ Date:_____

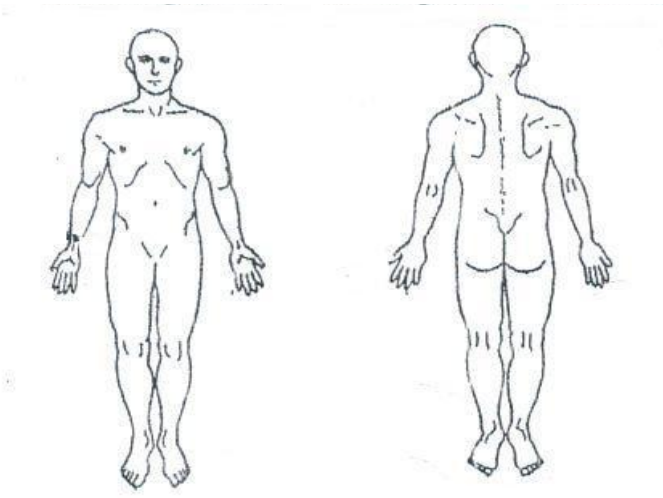
**Valley Center Chiropractic**

## QUALITY AND QUANTITY OF YOUR DISCOMFORT

| Area of Pain | "1" minor discomfort……."10" severe pain (please circle) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1._____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2._____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3._____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4._____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5._____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

On this drawing, please mark the type of pain you are experiencing in each area by using the codes listed:

Sharp (---) Stabbing (000) Aching (///) Burning (+++)



Please list any additional concerns about your symptoms or anything you may be experiencing that the doctor should know. _____
_____
_____

# Valley Center Chiropractic
# INFORMED CONSENT

Patients: Be sure to read the entire form and we would be happy to answer any questions you may have.

The primary treatments used by the doctors at Valley Center Chiropractic are the spinal adjustment (both manually and by hand held instrument), spinal decompression, physical therapy, and rehabilitation exercises. We will use our hands or a mechanical device upon your body in such a way as to move the joints. This may cause and audible "pop", much as you experience when you crack you knuckles. You may feel or sense movement when this occurs.

As part of you analysis, you consent to be examined, x-rayed if necessary, and to be treated by doctors and staff at Valley Center Chiropractic.

As with any health care procedure, certain complications may arise with an adjustment. They include: fracture, disc injury, dislocation, muscle strains, and nerve damage. Some types of manipulation have been associated with injury to neck arteries contributing to serious complications including stroke. The most common risk is temporary stiffness and/or soreness.

Chiropractic adjustments are considered very low risk. The probability of stroke resulting from an adjustment is estimated to be a risk rate of between one in one million to five million treatments. We employ tests in our examination procedures to try to identify patients who are at risk.

Other treatments offered in our office include electrotherapy, hot and cold packs, traction, ultrasound and rehabilitation exercise. These treatments involve no significant risks.

## OTHER TREATMENT OPTIONS AND THEIR RISKS

**Bed rest:** only recommended for one or two days at most as muscle deterioration can set in within hours, causing a condition to become reoccurring.
**Over-the-counter medicines:** can be helpful temporarily but can have undesirable side effects and are estimated to cause 16,500 deaths per year in the United States.
**Prescription medicines:** necessary at times but can also have undesirable side effects and are estimated to cause up to 98,000 deaths per year in the United States.
**Hospitalizations:** can be necessary for extreme cases but bears the risks of exposure to communicable disease and mishap. Estimates place the risk of dying from mishap while in the hospital as high as 120,000 per year.
**Surgery:** usually only recommended after failure of six weeks of conservative care. Risks include those associated with hospitalization plus reaction to anesthesia.
**Remaining untreated:** can allow the formation of adhesion and scar tissue which can complicate future treatment, making it more difficult, more expensive and less effective.

By signing below I indicate that I have read (or have had read to me) the above and understand the explanation of chiropractic treatment and other treatment options and the risks involved with each. By signing below I state that I have weighed the risks involved and have decided that it is in my best interest to undergo the treatment provided by the doctors at Valley Center Chiropractic and give my consent to that treatment.

Signature:_____

Print Name:_____

Date:_____ Witness:_____

**Valley Center Chiropractic**
**Patient Health Information Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that you records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of Health and Human Services about any possible violations of these policies and procedures without retaliation by this office
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature:_____ Date:_____

Print Name:_____

*For further information regarding this notice, please contact our office at (316)-755-9898*

Valley Center Chiropractic

# INSURANCE AND OTHER FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accidental insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

## GROUP OR INDIVIDUAL INSURANCE

We will make every attempt to verify your particular coverage; however, we cannot guarantee that your insurance company will quote the benefits correctly. We will wait for up to 30 days for response from your insurance company and you will be responsible for any non-covered service, deductible or co-payments.

## "ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job under Kansas's law you are allowed to seek care from the doctor of your choice. You must first obtain authorization from your employer. If your employer refuses authorization you are still eligible to receive up to $500.00, in "unauthorized" care. If you are unable to obtain your employer's insurance information prior to beginning treatment we will require a credit card guarantee to cover the treatment you receive. Upon approval of the claim for your services, we will return the guarantee.

## PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

If you do not have a claim number for your medical expense, you will either need to contact your insurance carrier OR provide us with a credit card guarantee prior to beginning treatment. If you have an attorney, we will request that your attorney sign a lien protecting Valley Center Chiropractic in the settlement of your case. If your attorney refuses to sign the lien, payment will be your responsibility. Although you are ultimately responsible for the charges, we will wait for payment as long as you are an active patient. If you suspend or terminate care prior to being released by the doctor payment will be due immediately.

## MEDICARE

The doctors at Valley Center Chiropractic are participating providers for Medicare. We provide a separate policy for Medicare patients. We file all claims to Medicare including Medicare secondaries.

## SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help filling.

## PAYMENT ARRANGEMENTS

All are welcome to participate in our "time of service discount:. In order to help keep the cost of health care down, we offer a discount to those who pay for services at the time they are rendered. We also have payment plans to fit every situation. Our staff will go over our estimated cost of care and work with you to make arrangements to allow you to receive the care you need.

## FLEX PLANS OF MEDICAL SAVING ACCOUNTS

Please let us know if you have a plan that allows you to be reimbursed for your medical costs. We will be happy to provide you with an itemization of your services.

## NOTE: WE MAY WANT TO SHARE INFORMATION WITH YOUR PHYSICIAN OR SPECIALIST, IF YOU OBJECT YOU MUST SIGN HERE:

_____ Date:_____

I have read and understand the above payment policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Valley Center Chiropractic and the insurance company. I request that Valley Center Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if I suspend or terminate my schedule of care as determined by Dr. Baldwin that fees will be due and payable immediately. I agree that any fees incurred in the collection of this account will be charged to me.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness