SIGNATURE CHIROPRACTIC

Patient Information

Full Name: _____ **Birth day**: _____ -_____-_____ ☐Male ☐Female

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

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Social Security #**: _____

Email Address: _____

Cell Phone: _____ **Home Phone**: _____

Employer: _____ **Occupation**: _____

Emergency Contact: _____ **Relation**: _____ **Phone**: _____

Do you have health insurance? ☐Yes ☐No

Insurance Company: _____ Member ID # _____ Group _____

How did you hear about our office? _____ Referred by: _____

Primary Care Doctor: _____ Phone # _____

Past History

	NAME	WHEN	CARE RECEIVED
INJURIES	1.		
	2.		
SURGERIES	1.		
	2.		

Medical History (select all that you have had or currently have)

- ☐ Ankle Pain
- ☐ Anemia
- ☐ Arm Pain
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chest Pain
- ☐ Congestive Heart Disease
- ☐ Cold Extremities
- ☐ Constipation
- ☐ COPD/Emphysema
- ☐ CVA (Stroke/Heart Attack)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Excessive Menstruation
- ☐ Eye/Vision Problem
- ☐ Fatigue
- ☐ Foot Pain
- ☐ Gout
- ☐ Hand Pain
- ☐ Headache
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Joint Stiffness
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Neurological Disorders
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis
- ☐ Shoulder Pain
- ☐ Significant Weight Change
- ☐ Sprain/Strain
- ☐ Stomach Problems
- ☐ Tumor
- ☐ Ulcers
- ☐ Wrist Pain
- ☐ Other: _____

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Social History

1. Alcohol Use: ☐Daily ☐Weekends ☐Occasionally ☐Never
2. Tobacco Use: ☐Current Smoker (Packs/Day) _____ ☐Former Smoker ☐Never Smoked
3. Sleeps: _____ hours Position _____
4. Stress: ☐None ☐Low ☐Moderate ☐Severe What causes stress? _____
5. Exercise: ☐None ☐3-5x/week ☐Daily

Family History

Family Members – Past and Present Health conditions (arthritis, cancer, diabetes, heart disease, scoliosis, etc.)

_____

List ALL medications you are taking and dosage: _____

List ANY allergies you may have: _____

Female: Are you currently pregnant or nursing? ☐Yes ☐No If **yes**, when is your due date? _____

Chiropractic History

Have you had previous chiropractic care? ☐Yes ☐No Name of Chiropractor: _____

Reason for care: _____ When? _____

History of Complaint

What is your primary area of complaint today? _____

Is this the result of any type of injury/accident? ☐Yes ☐No Type of Accident: ☐Auto ☐Work ☐Other

If **yes**, please explain: _____

What caused this condition? _____ Date condition began? _____

When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐late PM

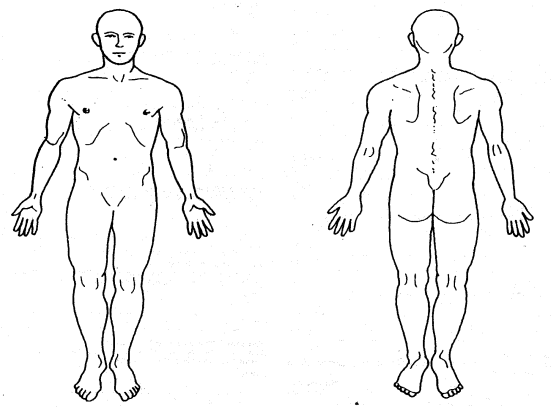
Have you had this condition in the past? ☐Yes ☐No

How often you feel the pain? ☐Constantly ☐Comes and goes ☐Frequently ☐Occasionally ☐Intermittently

How is this condition changing? ☐Getting Better ☐Getting Worse ☐Not Changing/Same

What activities aggravate your symptoms? _____

What relieves your symptoms? _____



Mark the areas and describe the pain:

☐Ache/Dull ☐Sharp/Stabbing ☐Burning ☐Throbbing

☐Radiating ☐Numbness/Tingling ☐Pins/Needles

Rate your pain **RIGHT NOW** on a scale of 0 to 10
(0 = no pain and 10 = worst possible pain)

0 1 2 3 4 5 6 7 8 9 10

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CONSENT FORM

Full Name: _____

HIPAA

I acknowledge that I have received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I hereby consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal law. I understand that this form will be placed in my patient chart and maintained for six (6) years. A full copy is available upon request.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments and any other associated chiropractic procedures on me, including various modes of therapy modalities and diagnostic x-rays on myself (or on the individual named below, for whom I am legally responsible) by Dr. Tiffany Le at Signature Chiropractic. I understand and am informed that, as in the practice of chiropractic there are some risks and certain complications, which may arise during chiropractic treatment. Those risks and complications include but not limited to: physical burns, fractures, disc injuries, strokes, dislocations, muscle strain, cervical myelopathy, and costovertebral strains and separations. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor of exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

X-RAY CONSENT

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. Dr. Tiffany Le does not diagnose or treat medical conditions; however, if any abnormalities are found, Dr. Le will bring it to your attention so that you can seek proper medical advice.

By my signature below I am acknowledging that the doctor has discussed with me the hazardous effects of ionization and I have conveyed my understanding of the risks associated with exposure to x-rays. *Female*: I have been provided a full explanation of the hazardous effects of radiation to an unborn child. After careful consideration, I hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

SIGNATURE **DATE**

To be completed by patient's representative if patient is a minor, physically or legally incapacitated.

Parent/Guardian Name (print): _____

Signature of Parent/Guardian: _____

Relationship to Patient: _____

OFFICE POLICIES

We want to thank you for choosing Dr. Tiffany Le as your chiropractic health provider. Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Late, Cancelation & No Show Policy
When you schedule an appointment, it is your responsibility to keep it. We will make every attempt to remind you via phone, text or email, but we cannot guarantee that you will receive a reminder.

For chiropractic appointments, if you miss or cancel with less than 24-hours notice, you have 24-hours from the time of the missed visit to schedule another visit within 2 business days to make up that appointment, or you will be charged a $35 late fee.

At times, there may be a need for Dr. Tiffany Le to cancel or reschedule an appointment. We will make every effort to notify you promptly and offer alternative appointment times as soon as possible. Please be sure you have updated your contact information so that we may reach you if necessary.

Payment Policy
All payments and cost of treatments are due at the time of your visit. There is a $30 fee for returned checks. Payments can be made by cash, check, or credit card.

Personal Responsibility Policy
Signature Chiropractic is in no way responsible for the safekeeping of your personal belongings while you are in an appointment or session.

Returns Policy
We cannot accept returns on purchased items, unless an item is defective. In this case please contact us to let us know, bring in the item, and we will exchange it for the same or similar item.

Photo Policy
We are PROUD of our patients and the progress they make while under our care! We love to CELEBRATE our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media (i.e. Facebook, Instagram, etc.) pages or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

☐ Sure! You can use my picture on the Signature Chiropractic Website and Social Media pages.

☐ No thanks! I'll pass for now.

Thank you for understanding Office Policies. Please let us know if you have questions or concerns.

I have read the Policy. I understand and agree to this Policy.

Initial ____

Medicare Patients:

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. WE WILL FILE ALL MEDICARE CLAIMS.

2. WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.

3. WE ARE PARTICIPATING PROVIDERS WITH MEDICARE WHICH MEANS THAT MEDICARE PAYS US DIRECTLY, HOWEVER, MEDICARE PATIENTS MUST MEET AN ANNUAL DEDUCTIBLE, WHICH WE ARE REQUIRED TO COLLECT AT THE BEGINNING OF SERVICES FOR EACH CALENDAR YEAR. SUPPLEMENTAL COVERAGE MAY PAY THE DEDUCTIBLE BUT IF NO SUCH COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE.

4. MEDICARE PAYS FOR **80%** OF ALLOWED CHARGES. SUPPLEMENTAL COVERAGE MAY PAY THE **20%**, BUT IF NO COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE.

5. MEDICARE **DOES NOT PAY FOR MAINTENANCE CARE**. THIS WILL BE YOUR RESPONSIBILITY.

6. MEDICARE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.

MEDICARE PAYS FOR:

-**Manipulation** of the spine
-IF SUPPORTED BY X-RAY AND/OR EXAMINATION
-After the deductible is met
-Depending upon the condition

MEDICARE DOES NOT PAY FOR:

-Examinations
-X-rays
-Therapies (muscle stim, hot/cold pack, etc)
-Nutritional supplements
-Orthopedic supplies
-Maintenance care
-Rehab

If you have questions regarding these guidelines, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

_____ _____

Signature of patient or person acting on patient's behalf Date