WELCOME TO OUR OFFICE

Care Chiropractic P.C · 3405 7th Ave, Ste 102, Marion, IA 52302 · 319-377-7331 · fax: 319-377-1407

PATIENT INFORMATION	DATE / /
Full Name	**INSURANCE INFORMATION**
Address	Please present your insurance cards and photo ID.
City/State/Zip	Policy Holder Name:
e-mail:	Birthdate: / / Self □Spouse □Child/Dep.
Birthdate: / / Sex: M F	Policyholder Employer:
□ Minor □ Single □ Married □ Widowed □ Partnered □ Divorced	
Employer/School:	**REFERRAL** How did you find our office?
Occupation:	Phonebook □Insurance □Internet □Location □Mailing □Sign □Patient, their name? _____
Home Phone: ( ) □Call 1st 2nd	
Work Phone: ( ) □Call 1st 2nd	**ACCIDENT INFORMATION**
Cell Phone: ( ) □Call 1st 2nd	Is condition result of an accident? □ YES □ NO
Emergency Contact:	Date of Accident: / /
Contact Phone:	Type: □ Auto □ Work □ Home □ Other
	Have you reported your accident?
□ **PRIVACY** Check your preferences below.	□Auto Insurance □Employer □ Worker's Comp □ Homeowner's Insurance
Leave message on voicemail/answering machine.	Attorney representing you?
□ Leave message with person other than patient.	Attorney Phone: ( )
□ e-mail is preferred contact method.	
□ Do not call at □ home □ work.	

Please do not hesitate to ask about fees. We will be glad to file insurance claims at no charge.

You are responsible for any balance not paid by your insurance company.

IF NO INSURANCE: Payment is due when treatment is given.

INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service or at the end of each month. It is your responsibility to provide us with the proper insurance card. If you discontinue treatment, any charges are immediately due and payable.

TREATMENT PERMISSION: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. A service fee of $5.00 per month will be charged on any balance over 60 days old. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent me by Care Chiropractic, P.C. shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Care Chiropractic P.C. to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Care Chiropractic P.C. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Care Chiropractic P.C. pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: If any insurance company or third party may be obligated to pay to me or to Care Chiropractic P.C. for charges for services, refuses to make such payment upon demand, I assign, transfer, and convey to Care Chiropractic P.C. the cause of action that may exist in my favor against such company or person. I authorize Care Chiropractic P.C. to prosecute said action either in my name or their name to collect fees due for care rendered at Care Chiropractic P.C. for legal expenses and to resolve said claims as they see fit.

AUTHORIZATION TO PROCESS DRAFTS: I agree that Care Chiropractic P.C. shall be appointed as my agent to endorse drafts or to sign my name on any checks for payment of my bill for chiropractic services rendered.

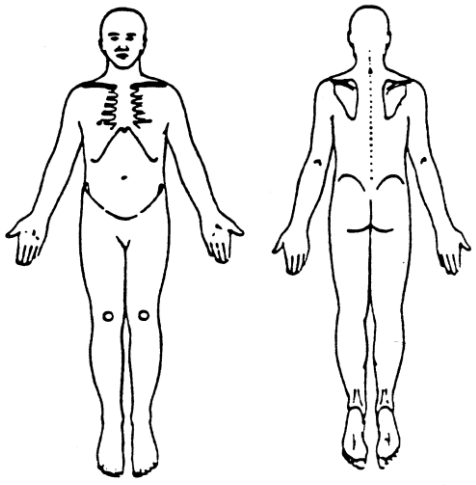
LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Care Chiropractic P.C. to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

PRINT NAME:_____SIGNATURE:_____Date:_____

PATIENT HISTORY	MEDICATIONS / SUPPLEMENTS
Where is your pain?	What medication are you taking? □Pain pills □ Muscle relaxers □Birth Control
	List:
Mark any symptoms that you currently have:	
□ Headaches □Nausea □Difficulty walking	
□Neck pain □Upper back pain □Joint pain	Do you take vitamins or minerals? □ YES □NO
□Jaw pain □Low back pain □Stiffness	List:
□Shoulder pain □Leg pain □Muscle spasms	
PAST HISTORY	**ALLERGIES:** Mark or list any allergies below.
List ALL past surgeries or procedures and approx. year:	□
Have you had any fractured bones? □YES □NO	Mark any diseases you have had below.
Where? When?	□Anemia □Heart Disease □Arthritis □Pneumonia
	□Measles □Mumps □Epilepsy □Influenza
Have you ever been hospitalized? □Y□N	□Mental disorder □Diabetes □Rheumatic fever
	□Eczema □Whooping Cough □Cancer □Alcoholism
Are you pregnant? □YES □NO	□Tuberculosis □AIDS/HIV □Venereal Disease
Do you have abnormal menstrual problems? □YES □NO	**ACCIDENT HISTORY**
PAST CHIROPRACTIC	Have you ever been in an auto or other accident? □Y □N
Have you ever seen a chiropractor before? □YES □NO	□Past year □Past 5 years □Past 10 years □Over 10 years
If yes, how long ago?	Any injuries?
Last chiropractor name:	Type of accident?
Location:	**HABITS**
Did your last chiropractor take x-rays? □YES □NO	Smoking (# pk/day) □Non-smoker
FAMILY HISTORY	Alcohol □never □rarely □daily □ weekly
Mother □ Diabetic □Heart □Kidney □Cancer □ Back	Coffee (# cups/day) □No caffeine
Father □Diabetic □Heart □Kidney □ Cancer □Back	Exercise □None □Daily □Moderate
Brother □Diabetic □Heart □Kidney □Cancer □ Back	What sports do you play?
Sister □Diabetic □Heart □Kidney □Cancer □Back	

Indicate areas of pain on the diagram below.



Informed Consent to Chiropractic Care

Nature and Purpose of Chiropractic Procedures

The practice of chiropractic includes many standard examination and testing procedures, including physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, radiology exams, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession –the chiropractic adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s).

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors.

AUTHORIZATON FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Signature_____Print Patient Name_____Date_____

(Patient or Representative if patient is a minor) Print Responsible Party _____