Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

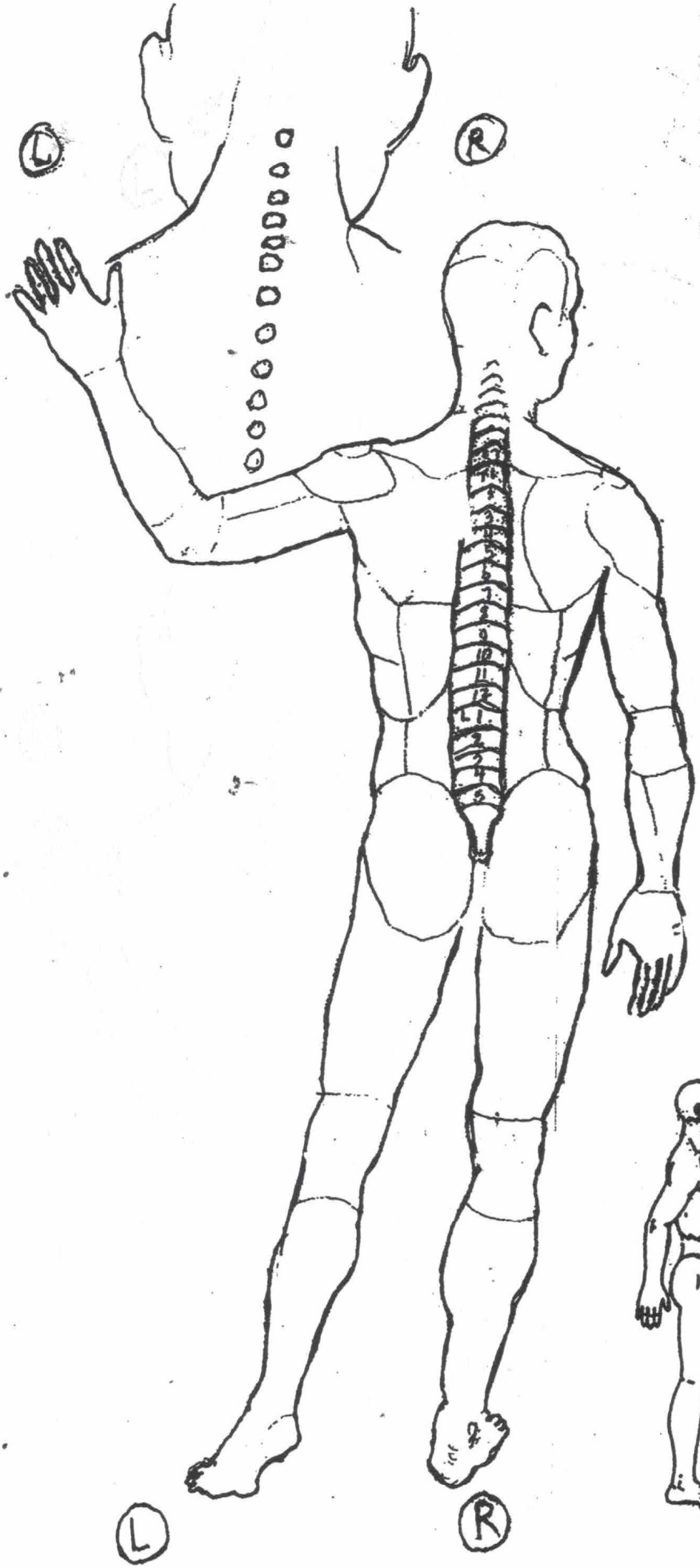
Signature _____ Date _____

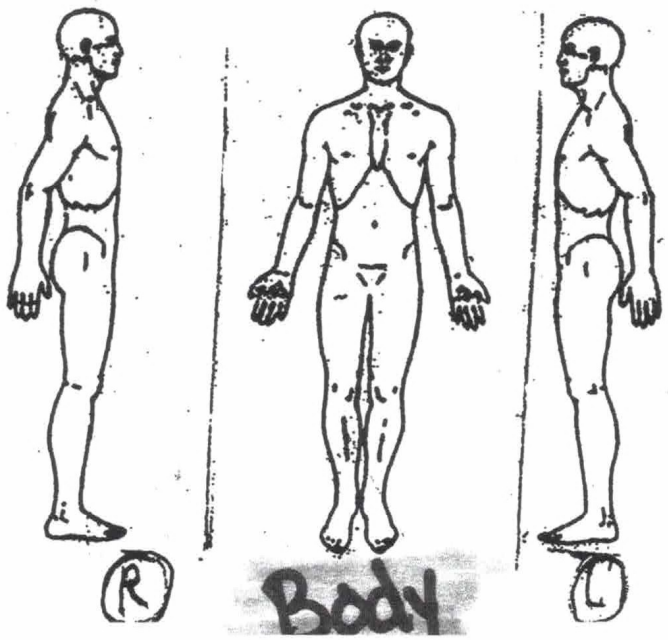
Payment is due in full at time of treatment unless prior arrangements have been approved.

PATIENT: _____

DATE: _____

ATTENDING: _____





Body

Payment and Billing Disclosure and Agreement

Initial here_____We will bill your insurance for you if we have the **complete information at the time of your visit**. If we do not have the necessary information, we ask that you make a full payment at the time services are rendered. **If you provide the necessary information within 7 days**, we will bill your insurance and when payment is received, a reimbursement check will be sent to you.

Initial here_____It is the responsibility of the patient to be and informed of the exclusions and inclusions of their insurance policy, including but not limited to co-pay and deductible amounts.

Initial here_____**If you do not have proof of insurance,** by signing this form you understand and agree that you are fully responsible for complete payment of medical fees at the time services are rendered.

Initial here_____**This office provides services that some insurance plans do not cover**. By signing this form you understand and agree to pay for those services you elect to receive at the time of service.

Initial here_____I authorize and instruct my insurance company to pay Lawson and Fisher Chiropractic directly the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy.

Initial here_____I authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved in this case.

Initial here_____Please be assured that we protect your information in accordance with HIPPAA Federal Law.

Initial here_____**A 24 hour cancellation notice is required or you will be billed $45. for the missed appointment.** By signing this you are acknowledging this policy.

_____ _____

Signature **Date**

LAWSON & FISHER CHIROPRACTIC PAYMENT AGREEMENT

Dear New Cash Patient,

Please Initial_____Welcome to our Office. We are looking forward to giving you the best care possible. At our office, we have a tight schedule to maximize the number of patients we see per day while also making enough time to meet your needs. When you break an appointment, 3 people suffer: You, the doctor, and the person who needed that appointment. **A 24-hour cancellation notice is required or you will be bill $45.00**. By signing this, you are acknowledging this policy. Thank you.

Please Initial_____**I agree to pay for each visit** on the day services are rendered, **via Cash, Check or Credit Card.**

Signature of Responsible Party_____

Date Signed_____

Informed Consent for Chiropractic Treatment of Your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop", and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer, and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cardiovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.

Other options for the treatment of pain include: do nothing- live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

_____

_____

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specific complicating factors and all other conditions that have caused me pain in the past.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Verbal Informed Consent with Physician: _____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (i.e insurance companies)
- Conduct normal healthcare operations such as quality assessments, physician certifications, and treatment.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

PRINT PATIENT NAME PATIENT DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE OF SIGNATURE