## NEW PATIENT APPLICATION

***Welcome to Corrective Chiropractic! Please answer all questions to the best of your ability. Thank you.***

Name:______________________________ Today's Date:____________

Address:______________________________

City/State/Zip:____________________ E-Mail:____________________

Phone: Cell:__________ (H):__________ (W):__________ Fax:__________

Birth date:____/____/____ Age:________

Marital status: ☐ Married ☐ Partnership ☐ Widowed ☐ Divorced ☐ Single

Number of Children:______ Children's names & ages:____________________

Employer Name:____________________ Occupation:____________________

Employer Address:______________________________

Spouse/Partner Name:____________________ Age:________

Spouse/Partner Employer:______________________________

Who may we thank for referring you? ______________________________

Favorite hobbies or interests:______________________________

Last time you went to a Doctor of Chiropractic:______________________________

Name of your prior Doctor of Chiropractic:____________________ City/State:____________

Chiropractic techniques you've had success with:______________________________

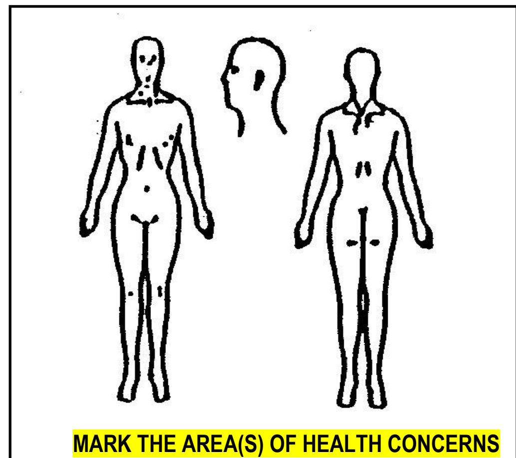
Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ FSA/HSA

Do you have health insurance? ☐ Yes ☐ No

Primary Insured: ☐ Self ☐ Spouse/Partner

General Practitioner Name:____________________

Phone:____________________



MARK THE AREA(S) OF HEALTH CONCERNS

CORRECTIVE
CHIROPRACTIC
*The Ultimate in Family Care*

Corrective Chiropractic
1131 Queensborough Blvd, Suite 101
Mount Pleasant, SC 29464
843-972-3174
www.correctivechiropractic.com/charleston/

Health reasons for consulting our office, ***with number one being of greatest importance***:

1.______________________________ 3.______________________________

2.______________________________ 4.______________________________

Please list any specialists you are currently receiving care from:

Name:______________________________ Phone: ______________

Name:______________________________ Phone: ______________

Have you had same or similar problem(s) before? ☐ Yes ☐ No

How long?____________ Please explain:______________________________

Do any of the following immediate family members have the same condition?
☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children

Are you interested in our nutrition program and a healthier diet plan? ☐ Yes ☐ No

What is your primary nutritional goal? Weight loss ☐ Muscle Gain ☐ Detox ☐ Disease Prevention ☐ Increased Energy ☐

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what type?______________

If Yes, are you presently undergoing treatment? ☐ Yes ☐ No If so, what type?______________

| Do you still have your: | | | | | |
|---|---|---|---|---|---|
| | Appendix | ☐ Yes ☐ No | | Gall Bladder | ☐ Yes ☐ No |
| | Tonsils | ☐ Yes ☐ No | | Reproductive Organs | ☐ Yes ☐ No |

Please list any surgeries you have had: ______________________________

Is the reason for your visit the result of an auto or work injury? ☐ Yes ☐ No If yes, when?______________

Other doctors who have treated this problem:______________________________

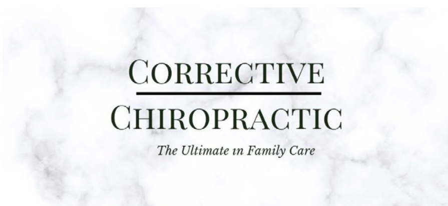
Medication(s) you currently take:______________________________

What have you heard about chiropractic care?______________________________

Do you know what a subluxation is? ☐ Yes ☐ No If yes, please describe______________________________

What daily rituals for spinal health do you presently practice?______________________________

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.
Patient or Guardian Signature:______________________________ Date:______________

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# *Developmental Milestones*
## *Normal Guidelines*

*Please indicate the skills your child has accomplished and when they accomplished it, especially noting if they had any problems or delays.*

Child's Name:________________________ Date __________________________

DOB:________________Age:_________________Sex: M F

**GROSS MOTOR SKILLS**

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4 weeks Able to hold head up from the table face down ________

3 mths Head and shoulder supported by the forearms face down________

4 mths Infant can sit with assistance___________________

6 mths Sits unsupported in the upright position ______________

6 mths Rolls from a face down to a face up position_________ _

9 mths Crawls _______________

9 mths Stands holding onto furniture ________________

11 mths Walks with someone holding onto one hand __________

12 mths Walks unassisted ________________

2 years Runs _____________

**SOCIAL SKILLS**

2 mths Smiles______________

3 mths Reaches for familiar objects ___________

4 mths Plays with hands _____________

6 mths Plays with feet _______________

9 mths Clearly shows joy and pleasure _____________

12 mths Feeds self with fingers _______________

15 mths Plays peek-a-boo______________

18 mths Understands yes and no ______________

**FINE MOTOR SKILLS**

At birth Primitive grasp reflex present ________________

4 mths Holds and shakes a rattle placed in the hand _________

5 mths Grasps objects independently ________________

6 mths Moves an object from one hand to the other_________

6 mths Checks objects by placing them in the mouth_________

10 mths Feeds from a cup unassisted_______________

12 mths Picks up object with thumb and index finger________

12 mths Holds own bottle______________

15 mths Turns 2 to 3 pages of a book at a time____________

18 mths Turns pages of a book one at a time _____________

20 mths Feeds self with utensils_________________

24 mths Builds a tower containing at least 5 blocks__________

**COMMUNICATION SKILLS**

7 weeks Makes cooing sounds__________________

3 mths Laughs_____________

5 mths Uses one syllable words such as "da"__________

8 mths Uses 2 syllable words such as "dada"__________

12 mths Uses 2 to 3 word vocabulary______________

24 mths Uses 2 to 3 word phrases______________

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# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident and Health Insurance

I hereby authorize and direct________________________________Insurance Carrier to pay by check made out and mailed directly to:

**Corrective Chiropractic**
**1131 Queensborough Blvd,**
**Suite 101 Mount Pleasant,**
**SC 29464**
**843-972-3174**

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made to me and mailed as follows:

**Corrective Chiropractic**
**1131 Queensborough Blvd,**
**Suite 101 Mount Pleasant,**
**SC 29464**
**843-972-3174**

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and have I agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

________________________________ ________________________________
**Signature of Policyholder** **Witness**

________________________________ ________________________________
**Signature of Claimant if other than Policyholder** **Date**

________________________________
**Date**

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# HIPAA

# PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

Date: ____________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

| ________________________ | ________________________ |
| --- | --- |
| Please ***print*** name of Patient | Please ***sign*** for Patient / Guardian of Patient |
| ________________________ | ________________________ |
| Legal Representative / Guardian | Relationship of Legal Representative / Guardian |

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**Informed Consent**

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

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I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of 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. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE** CORRECTIVE CHIROPRACTIC **TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.**

**DATED THIS______DAY OF_____________, 20___**

**Patient Signature** **Doctor's Signature**

**Parental Consent for Minor Patient:**

**Patient Name: _________________________________ Printed name of person legally authorized to sign for Patient:______ ____________________________________________ Signature: _____________________________________________**

**Relationship to Patient: ________________________**

**In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.**

**Printed name of person legally authorized to sign for Patient: _____________________________________________**

**Signature:_______________________________________**

**Relationship to Patient: ________________________**

**Remarks:**

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# HIPAA Authorization for Use or Disclosure of Patient Photographic and/or Video Images Form

**Authorization:**

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

**Purpose:**

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.

**Revocability:**

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

**No Treatment Conditions:**

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, a copy can be provided if you ask a team member.

**Patient Name:** ___________________________________

Date: ___________________________________________

Signature: ________________________________________

**If Personal Representative and/or If Patient is a Minor:**

Name: __________________________________________

Date: ___________________________________________

Signature: ________________________________________

Relationship to Patient: ____________________________