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:_____

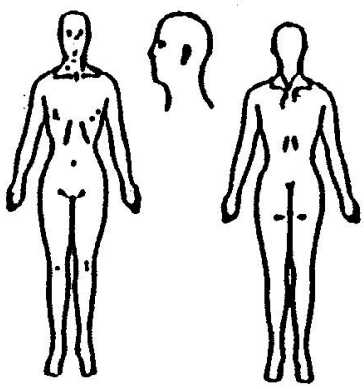
Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ FSA/HSA

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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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	

Individual Request to Protected Health Information

Individual Request for Access to Protected Health Information

_____

Under the Health Insurance Portability and Accountability Act, you have a right of access to inspect and obtain a copy of your health information contained in a Designated Record Set. The "Designated Record Set" includes information such as medical records and billing records maintained by or for a covered health care provider or records used to make decisions about individuals. This right does not apply to:

1. Psychotherapy notes;
2. Information complied in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
3. Protected health information that is:

a. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to you would be prohibited by law; or
b. Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

Please indicate the specific information to which you are requesting access:

Corrective Chiropractic will act on this request within 30 days of the date listed above or, within 60 days if the requested information is not maintained or accessible to Corrective Chiropractic on-site. Such action will either inform you of the acceptance of the request and provide you with the requested access; or provide a written denial explaining the reasons for the denial and whether you are entitled to have the denial reviewed.

If the requested information is contained in more than one Designated Record Set or at more than one location, and access is granted, Corrective Chiropractic needs only to provide you with access to information contained on one of the Designated Record Sets.

Please indicate the form or format you would like to receive your requested information (e.g. hard copy, e-mail, other): E-mail

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (mail, on-site, fax etc., and provide the necessary numbers or address where the information should be directed):

If Corrective Chiropractic cannot readily produce the information in the form or format you have requested such information will be made available to you in a readable hard copy form or other form or format agreed to.

Do you agree to receive a summary of the requested information in lieu of access? ✓ Yes ___No

Corrective Chiropractic may impose a fee of $20 to cover the cost of labor, copying, postage, and preparing a summary of the requested information. Do you agree to such fees imposed by Corrective Chiropractic for providing a copy or summary of the requested information? ___Yes ✓ No

_____

Printed Name and Legal Signature Today's date

Acknowledgement of Receipt of NPP

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

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

The patient was unable to sign because ____

Other (please describe) _____

Signature of Privacy Officer

_____

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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: _____
Patient age: _____ DOB: _____
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: