Convergence Chiropractic Clinic

Chiropractic Case History/Patient Information

Date _____ Patient ID_____

Name _____ Social Security #_____

Email address _____ Phone Number _____

Address_____City_____ State_____ Zip _____

Age_____ Date of Birth_____ Marital Status: M S W D Height _____ Weight _____

Employer_____ Occupation_____

Emergency Contact's Name (Relation)_____(_____) Phone_____

How were you referred to our office? _____

Please list the name of any other healthcare/fitness professional you authorize your doctor to communicate with.

Name of medical doctor_____ at _____

Name of fitness/exercise professional _____ at _____

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company_____ Insured's ID# _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, logistical operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

_____

_____

Patient ID_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief complaint (purpose of this appointment) _____

Date symptoms appeared or accident happened _____

Is this due to Auto_____ Work_____ Other _____

Describe _____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:

_____

Days lost from work _____ Date of last physical examination _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):

_____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe _____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe _____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe _____

Do you have any congenital condition? ____Yes ____ No

If yes, describe _____

Women - Are you pregnant at this time? _____

I certify the information provided is accurate to the best of my knowledge:

Printed Name of Patient _____ Date _____

Printed Name of Guardian _____ Date _____

Signature _____ Date _____

Convergence Chiropractic Clinic

Informed Consent to Chiropractic Care

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of Care; Alternatives. Chiropractic manipulation / adjustment - As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays - I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant.

Other Potential Alternatives - I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Printed Patient Name _____

Signature _____

Date _____

Name of Parent / Guardian / Authorized Representative _____

Signature _____

Date _____

Convergence Chiropractic Clinic

Financial Policy

Thank you for choosing Convergence Chiropractic Clinic (hereinafter referred to as "Office") as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. Our Office is not party to that contract. You are responsible to know your policy. Your account balance at our Office will become your responsibility if denied by your carrier for any reason. You do reserve the right to appeal the reimbursement for services or lack thereof with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore, considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to our Office to be credited to your account. Should payment be sent to you, it is your responsibility to return the payment to our Office within seven (7) days of receipt. Failure to do so may result in civil collection proceedings wherein you agree to pay our reasonable attorney fees and costs for collection as well as potential criminal liability for theft and conversion of funds. You further assign your rights to benefits under your insurance contract or other third party payer to our Office and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plans.

You hereby further provide Convergence Chiropractic Clinic with a limited, irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually or jointly to you and this office. This power expressly authorizes third parties, including but not limited to, commercial banking institutions to honor our endorsement on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

If your insurance plan requires a referral prior to the commencement of your treatment at our Office, it is your responsibility to obtain one prior to any treatment.

Our Office reserves a portion of time to spend with you on each visit. Cancelling or "no-showing" causes a loss of this time. We ask that you make every effort to keep your scheduled appointment or to give this office a 24-hour notice of any change or cancellation. If not, we reserve the right to charge you for the missed visit. This fee will not be covered under any insurance contract.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND THE HEALTHCARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

Printed Patient Name _____

Signature _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

AND INFORMATION PRACTICES

By signing below, I acknowledge that I have received a copy of the Notice of Privacy and Information Practices.

Printed Patient Name (or Personal Representative) _____

Signature _____

Date _____

_____
If signed by personal representative, relationship to patient

---

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____
_____
_____
_____

Employee Signature:_____ Date:_____