Tundra Chiropractic

Last Visit	Today's Date	Patient ID#
_____	_____	_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

Patient Name: _____ **DOB:**_____

Address: _____ **City:** _____ **Zip Code:** _____

E-Mail: _____ **Phone #:** _____

Occupation: _____ **Employer:** _____

Marital Status: S M D W

How did you hear about Tundra Chiropractic? _____

Insurance: Yes No Insurance Company: _____

Present Complain (describe symptoms): _____

How long have you experience symptoms? _____

Indicate the average intensity of your symptoms:

☐ 0 (no pain) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐9 ☐ 10 (worse pain)

Since your problem began, is the pain:

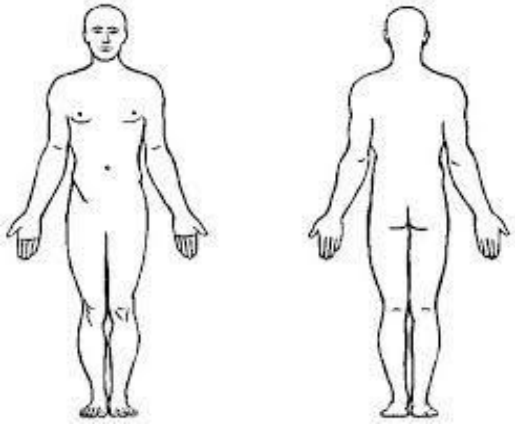
☐ Getting Better ☐ Not Changing ☐Getting Worse

How often do you experience symptoms?

☐ Intermittent (0-26%) ☐ Occasional (26-50%) ☐ Frequent (51-75%) ☐ Constant (76-100%)

Circle the area(s) of complaint and put the number(s) that describe your pain in the appropriate area(s).

1. Sharp/shooting
2. Dull Ache
3. Numbness
4. Burning
5. Tingling
6. Headache
7. Radiating Pain
8. Inflammation
9. Throbbing
10. Pain on Movement
11. Deep
12. Aching
13. Cramping
14. Stiffness



What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Sleeping ☐ Reaching ☐ Lying Down

☐ Movement ☐Stretching/Exercising ☐ Running ☐ None ☐ Other: _____

What makes your symptoms better?

☐ Sitting ☐ Standing ☐ Lying Down ☐ No movement ☐ Movement ☐ Heat ☐ Ice ☐Medication

☐ Adjustments ☐No Relief ☐ Other: _____

I consent to a professional and complete chiropractic examination and to any radiographic examinations that the doctor deems necessary. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

_____ _____

Patient/Parent/Guardian Signature Date

Appointment Reminder

Please choose **one** reminder option

☐ Option 1:

Text Message Reminder

Cell Phone Number:

****Who Is Your Service Provider** (ie: Sprint, Verizon, US Cellular…):

↳ ***needed to route text message***

☐ Option 2:

Email Reminder

Email Address:

**We do not give out, nor would want to, your email address or phone number for any reason without your permission.*

Appointment Sign In

In order to stay compliant with health care initiative laws (HIPAA), we will have you sign-in for each appointment with a self-selected pin.

Please write your 4 digit numeric pin. *If you forget, we can look it up.*

Already have a pin? Let us know!

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that unlike many other health care professions, the risk associated in receiving chiropractic care is extremely minimal. In recent years there have been rare incidents or injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with the attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At Tundra Chiropractic, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I _____ have fully read and understand the above statement.
(PRINT PATIENT'S NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Kallie and Dr. Cory Madison.

_____ _____ _____

(SIGNATURE) (DATE) (WITNESS)

CONSENT TO ASSESS AND ADJUST A MINOR:

I _____ , being the parent or legal guardian of _____ have
(PARENT/GUARDIAN NAME) (CHILD'S NAME)

read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

Tundra Chiropractic

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use for Health Information

Name: _____ Date: _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

By: _____
Patient's Signature

If patient is a minor or under guardianship order as defined by state law:

By: _____
Signature of Parent / Guardian (circle one)

Tundra Chiropractic

Office Policies

Cancellation/No-Show Policy: We are committed to offering the best service to everyone who needs our services. Therefore, we require a minimum 24-hour cancellation notice on all appointments, unless in cases of emergency. **We will bill you $25 for your second missed appointment if not cancelled within 24 hours.**

Late & Rescheduling: Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Need Extra Time?: If you think of other problems you wish us to work on during your appointment, please let us know and we will be happy to schedule additional time for your next appointment.

Insurance: Your insurance is an agreement between you and your insurance company. We offer a complimentary benefits check to verify coverage; however, the **benefits quoted to us by your insurance company are not a guarantee of payment**. You are responsible for payment of any non-covered services, deductibles or co-pays.

Refunds: Refunds for services not rendered are rare. In the event you cannot complete care, we will be happy give you a refund for services not rendered minus a 6% convenience fee.

Time of Service: We understand not everyone has chiropractic coverage. A discount can be applied when you pay on the same day as the treatment given, but not to supplies used. *Once the discount is given, it cannot be billed to an insurance company.*

Injury/Worker's Compensation: If your condition is due to an injury, please let us know on your first visit in the clinic and give us any billing information. If we do not receive the billing information on your first visit, the full amount will become your responsibility. We do not accept third party billing or attorney assignments.

I have read, understand and agree to Tundra Chiropractic's Office Policies.

_____ _____

Patient Signature Date