Schieber Chiropractic & Acupuncture

NEW PATIENT DATA

***TODAY'S DATE*: _____**

NAME: _____ DOB: ____/_____/_____

SS#: _____ SEX: (circle one) M / F

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE (hm): _____ (cell): _____ (wk): _____

Is it okay to contact you at work? (Circle one) **YES / NO

***EMAIL:** (PLEASE PRINT) _____

**(For newsletters, clinic updates, etc.)

EMPLOYER: _____

Please fill out this section if applicable

SPOUSE NAME: _____ PHONE (cell): _____

If spouse is primary insurance card holder, please list the following:

SPOUSE SS# _____ SPOUSE DOB: _____/_____/_____

EMERGENCY CONTACT: _____ PHONE: _____

Do we have your permission to discuss your care with anyone? (Circle one) YES / NO

**If yes, who? _____ Relationship: _____

PHYSICIAN: _____ CLINIC NAME: _____

Whom may we thank for referring you? _____

Referral Recognition

Most patients are referrals from current patients. I give my consent to Schieber Chiropractic & Acupuncture to allow my name on a referral board as recognition and thanks for when I refer someone into this clinic for care. *Please Initial*: ____

Patient Signature: _____

FEMALE PATIENTS ONLY: Are you pregnant? **(Circle one) YES / NO** If yes, how far along?_____

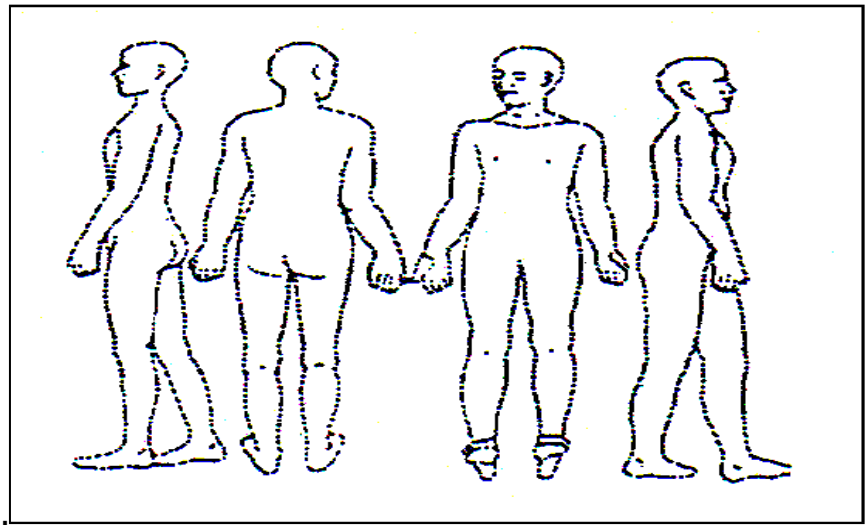
What is your health goal with us? (Circle one)
A) Pain Relief Only
B) Pain Relief & Correction
C) Pain Relief, Correction & Maintaining Quality of Health

Please describe your symptom(s):_____
_____
_____
How long have you had this problem? _____
What have you done for it? _____
What activities aggravate your condition? _____
Have you been treated for any health conditions in the past year? (Circle one) **YES / NO**
If *YES*, please describe: _____
_____
Have you had any previous surgeries, illnesses or accidents? (Circle one) **YES / NO**
If *YES*, please describe: _____
_____
Are you currently taking any prescription medications? (Circle one) **YES / NO**
If *YES*, please list: (turn page over for more room, if needed) _____
_____

Pain Index
Circle the # that *best describes* your level of pain: ***Least*** **-- 1 2 3 4 5 6 7 8 9 10 --** ***Worst***
How much of the day do you feel discomfort? (Circle one) **25% 50% 75% 100%**
Does the pain/sensation travel? (Circle one) **YES / NO**
If *YES*, from where to where? _____

Please Check *ALL* Pain Symptoms: ***Please check all that apply:***
___ Burning ___ Tingling ___ Numbness ___ Spasm ___ Tenderness ___ Sharp ___ Dull ___ Ache
Is the pain? (Check one) ___**Constant** ___**Occasional**

Please mark an X on the diagram below as to where the pain is located:



Other Health Concerns: *Please check all that apply:*
__ Fatigue __ Low Back Pain __ Nausea __ Cancer __ Stress __ Neck Pain/stiffness
__ Asthma __ Muscle spasms __ Allergy __ Kidney infection/stones __ Heart Disease __Sciatica
__ Headache __ Diabetes __ Bruise easily __ Urination problems __ Loss of Sleep
__ Spinal curvatures __ Blood Pressure __ Ankle swelling __ Depression __ Digestion problems
__ Sinus problems __Dizziness __ Poor Circulation __ Chest Pain __ Breathing problems __ Ear Ache

Please *Rate* the Following: (Please use *these 3 words* to describe) ***Poor, Good*** or ***Excellent***
Diet _____ Exercise _____ Sleep _____ General Health _____

Do you currently take vitamins/supplements: (Circle one) **YES / NO**
If *YES*, please list: _____

Family Health Profile:
At our office we are not only interested in your health and well-being, but also the health and well-being of your family. Please list any health conditions or concerns you may have regarding:

Spouse: _____

Child(ren): _____

Parent(s): _____

Sibling(s): _____

Other: _____

Privacy Practices ~ HIPAA Form

I have received or reviewed the privacy practice notice for chiropractic care and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit; whenever that may have occurred. I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in the HIPAA privacy practices statement.

_____ _____
Patient Signature Date

_____
Print Name

Informed Consent to Care
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at Schieber Chiropractic & Acupuncture.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to; fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Jon Paul Schieber, D. C., F.A.S.A

_____ _____
Patient Signature Date

Insurance Information Necessary If Patient is *not* Primary Card Holder:

Insured's Name: _____ ID#:_____
Insured's DOB: _____ Relationship to Insured: (circle one) Spouse / Child /
Insured's Sex: (circle one) M / F Insured's Employer:_____
Secondary Ins. Co: _____

We invite you to discuss with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient.

Please initial each item:

___ I understand and agree that you will submit my claims; however, no matter what insurance pays, I am ultimately responsible for the charges that I incur. I understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable within an appropriate amount of time.

___ I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

___ I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my medical status.

_____ _____
Patient Signature *or* Parent / Guardian Date

Financial Agreement

To better serve our patients, we offer personalized payment plans upon your 2nd visit. An initial payment* is required upon completion of your 1st visit, if applicable. *(Inquire at desk for details)

If circumstances in your life prevent you from making your payment, please call us as soon as possible to make other arrangements. Please realize that if no payment is received within a 30-day period, the account is considered past due. Any account 60 days past due (without other arrangements made) will be turned over to our collection agency without notice. I fully understand and agree to the terms of this financial agreement.

_____ _____
Patient Signature *or* Parent / Guardian Date

For convenience, we keep credit card info on file, applying your portion automatically.

Apply charges monthly: (Select date) ( )15th ( )22nd Apply $_____ /mo on my card until balance is paid.

V / MC / Disc #_____ exp. _____

Billing Zip Code: _____ Name on card: _____

Authorized Signature: _____ Date_____

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPPA and Consent

For Use of 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 HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.

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

_____I agree to allow texts, voicemails and /or e-mails for appointment reminders or other information regarding my care.

Date:_____

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)