Tri County Chiropractic, S.C.

Glen E. Rooyakkers, D.C. Wanda J. Roebke, D.C. Jason J. Weyenberg, D.C. Jared S. Bedor, D.C.

Patient Information

Name:_____ Date:_____

Address:_____ City:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Marital Status: □ Married □ Single □ Divorced □ Widowed Date of Birth:_____

Employer:_____ □ Full-Time □ Part-Time

Address:_____ City:_____ Zip Code:_____

Occupation:_____ Work Phone:_____

Spouse's Name:_____

Employer:_____ □ Full-Time □ Part-Time

Address:_____ City:_____ Zip Code:_____

Occupation:_____ Work Phone:_____

Choice of Payment – Please Select only one!

□ Health Insurance □ Auto Insurance (Date of Accident:_____)

□ Same Day Rate □ Workman's Comp (Date of Injury:_____)

*How did you hear about Tri County Chiropractic?*_____

I have presented to Tri County Chiropractic, S.C. for treatment and give them full consent to treat me for my presenting complaints. I also understand that health and accident insurance policies are an agreement between an insurance company and myself. I understand that Tri County Chiropractic, S.C. will prepare any necessary forms required by an insurance carrier, charging my account a usual customary amount for such reports. Any amount authorized to be paid to Tri County Chiropractic, S.C. will be credited to my account on receipt. I hereby direct the insurer to pay without equivocation directly to Tri County Chiropractic, S.C. any and all benefits due them as a result of this claim. I clearly understand that I am personally responsible for services and balance not covered by insurance.

I also authorize the release of any and all medical information necessary to process my claim. In the event, I discontinue care for any reason, I understand that my full balance is due and payable immediately. This statement shall remain in effect until I choose to revoke it in writing.

I have been offered a copy of Privacy Practices at Tri County Chiropractic, S.C. This notice provides a more complete description of the uses of my health information. I have the right to request in writing restrictions on how my records may be used or disclosed. Tri County Chiropractic, S.C. is not required to agree to restrictions.

Signature of Responsible Party:_____ Date:_____

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Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, and phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use to disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If yo udo not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire in seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of Personal Representative's Authority to Act for the Patient

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Informed Consent to Chiropractic Treatment

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Chiropractic offices may use trained staff/personnel to assist in portions of your consultation, examination, x-rays, physiotherapy application, exercise instruction, etc. Occasionally when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with chiropractic care:

Stroke: Stroke is the most serious complication of chiropractic treatment. It is, on rare occasion due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On the extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment does pose small risk. The chances of this occurring are estimated at *1 per 400,000 treatments to 1 per 10 million treatments*. The most recent studies (Journal of CCA, Vol.37, No.2 June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib/bone injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib or other bone injury or fractures. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare but should be reported to your Doctor of Chiropractic or staff if they occur

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they include joint dislocation, nerve, or spinal cord injury.

Other Treatment Options Which Could Be Considered May Include the Following:

- **Over-the-counter analgesics**. The risks of these medications include irritation to the stomach, liver, and kidneys, and other side effects in a significant number of cases.
- **Medical care**, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risk of these drugs include a multitude of different undesirable side effects and patient dependence in a significant number of cases.
- **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable diseases in a significant number of cases.
- **Surgery** in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in significant number of cases.

Chiropractic is a system of health care delivery and, therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have an understanding and consent to care provided, please print your name, sign and date below. Thank you!

Patient Name	Date
Patient Signature	Parent of Guardian Signature for Minor

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Acknowledgement of Receipt of Notice of Privacy Practices

This Form will be retained in your medical record

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ Date of Birth:_____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf Tri County Chiropractic, S.C.

I understand that the Notice describes the uses and disclosures of my protected health information by Tri County Chiropractic, S.C. and informs me of my rights with respect to my protected health information.

Patient Signature or that of a Legal Representative	Printed Name of Patient or that of a Legal Representative
Today's Date	If Legal Representative, Indicate Relationship to Patient

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient Refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ Other (please specify): _____

Employee Signature

CONFIDENTIAL HEALTH HISTORY FORM

Patient Name: _____

General
__ Headache
__ Fever
__ Chills
__ Night Sweats
__ Fainting
__ Dizziness
__ Convulsions
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Allergy (What?)
__ Wheezing
__ Neuralgia
__ Aids/HIV
__ Mental Disorder
__ Lyme Disease
__ Bleeding Problem
__ Anemia
__ Epilepsy
__ Diabetes
__ Cancer
__ Thyroid Disease/Goiter
__ Alcoholism
Drug Use

Muscle and Joints
__ Weakness
__ Twitching
__ Stiff/Painful Neck
__ Backache
__ Swollen/Painful Joints
__ Tremors
__ Numbness/Pain (arms & legs)
__ Hernia
__ Low Back Pain
__ Muscle Aches/Soreness
__ Spinal Curvature
__ Arthritis

Habits
Smoking ___packs/day
for ___ years
Alcohol ___ days/week
Coffee ___ cups/day
__ Recreational Drug Use

Respiratory
__ Chronic Cough
__ Spitting Blood
__ Chest Pain
__ Spitting Phlegm
__ Difficulty Breathing
__ Wheezing/Asthma
__ Pneumonia
__ Tuberculosis

Eye, Ear, Nose, Throat
__ Poor Vision
__ Crossed Eyes
__ Deafness
__ Earache
__ Ear Noise
__ Ear Discharge
__ Tonsillitis
__ Sinus Trouble
__ Nasal Obstruction
__ Nose Bleeds
__ Sore Throat
__ Hoarseness
__ Hay Fever
__ Frequent Colds
__ Enlarged Thyroid

Gastrointestinal
__ Poor Appetite
__ Difficulty Swallowing
__ Excessive Hunger
__ Belching or Gas
__ Nausea
__ Vomiting
__ Vomiting Blood
__ Pain over Stomach
__ Ulcer
__ Constipation
__ Black or Bloody Stool
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids (Piles)
__ Liver Trouble
__ Jaundice
__ Gall Bladder Trouble
__ Appendicitis

Cardiovascular
__ Rapid Heartbeat
__ Slow Heartbeat
__ High Blood Pressure
__ Low Blood Pressure
__ Pain Over Heart
__ Prev. Heart Trouble
__ Swelling of Ankles
__ Poor Circulation
__ Strokes
__ Varicose Veins
__ Rheumatic Fever
__ Irregular Heartbeat

Skin Allergies
__ Skin Eruptions
__ Itching
__ Bruising Easily
__ Dryness
__ Boils
__ Sensitive Skin
__ Hives/Allergy
__ Eczema
__ Medicines
__ Change in Mole(s)
__ Skin Cancer

Genitourinary
__ Frequent Urination
__ Painful Urination
__ Blood in Urine
__ Kidney Infection
__ Bed Wetting
__ Inability to Control Urine
__ Difficulty Starting Flow
__ Get up ___ Times a Night
__ Breast Lump or Pain
__ Venereal Infection
__ Sexual Difficulties

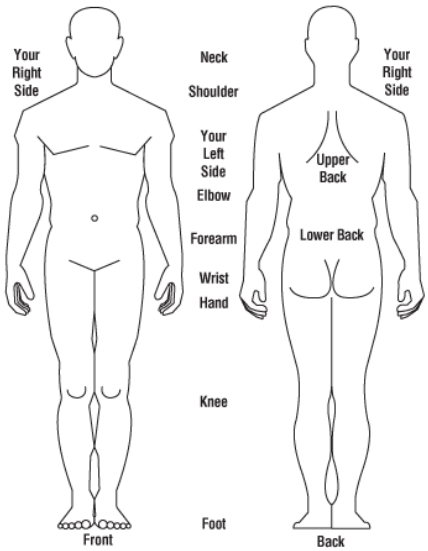
Exercise
__ None
__ 1-2 Times/week
__ 3-5 Times/week
__ 6+ Times/week

Women Only
__ Birth Control
__ Painful Periods
__ Excessive Flow
__ Irregular Cycle
__ Hot Flashes
__ Cramps/Backache
__ Miscarriage
__ Vaginal Discharge
__ Pregnant Right Now
Date of Last PAP_____

Men Only
__ Testicular Swelling/Pain
__ Prostate Problems

Family History
(Immediate Family)
__ Diabetes
__ Thyroid Disease
__ Tuberculosis
__ Kidney Disease
__ High Blood Pressure
__ Heart Disease
__ Cancer
__ Muscle, Bone, or Nerve Disease

Please Mark Your Areas of Pain on the Figures Below



Purpose of this Visit:_____
Do you suffer from any condition other than that which you are now consulting us?_____
List any prescription medications:_____
List any surgeries:_____