ADVANCE
UPPER CERVICAL CHIROPRACTIC
KAPLAN MCCLELLAND CORPORATION

The following information is needed in order to better serve you. Please complete all questions.
If you need help with reading the content, please ask the receptionist.

Today's Date:_____ ***Referred by:*** _____

Name:_____

Cell Phone: _____ Home Phone: _____ Office Phone:_____

E-mail Address:_____

Address: _____ City:_____ State: _____ Zip: _____

Age:_____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Please Check Type of Payment: Cash/Debit Check Credit

Name of Spouse or Parent: _____ Birth Date:_____

Occupation: _____ Years on Job: _____

Describe The Major Complaints That Bring You To Our Office:

_____

_____

Is Your Condition Due To An Accident? ❑Yes ❑No Date of Accident:_____

Type of Accident? ❑Auto ❑Work/Job ❑At Home ❑Other:_____

Would you like us to check your Insurance and see if you are covered for our Chiropractic Services? ❑ Yes ❑ No

(Please give your Insurance Card and Driver's License to front desk receptionist)

Would you be interested in Appointment Reminders? ❑Text (SMS Service if checked_____) ❑ Email ❑ No Thanks

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature:_____ ***Date:*** _____

Guardian's Signature (For Minors):_____ ***Date:*** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

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Health History

List All Current Health Problems:

_____
_____
_____

List Any Other Doctors/Practitioners/Therapists seen for the above problems:

_____
_____
_____

List Current Primary Physician:

_____

List All Surgeries And Their Dates:

_____
_____
_____

List Any Medications and/or Supplements You Are Taking:

_____
_____
_____

List Any Traumas And Their Dates:

_____
_____
_____

Please list any DIAGNOSED CONDITIONS that you have or have had: _____

_____

_____

Please check all PRESENT SYMPTOMS:

Cardiovascular:
( )Swelling in arms/legs
( )Irregular heart beat
( )Cold hands/feet
( )Chest pain

Vertebrobasilar:
( )Vision problems
( )Memory problems
( )High blood pressure
( )Dizziness
( )Previous head/neck trauma

Head:
( )Headaches
( )Migraines
( )Vertigo
( )Loss of Hearing
( )Ringing in ears
( )Loss of balance
( )Loss of taste
( )TMJ/Jaw clicking/pain

Neck:
( )Neck pain
( )Limited neck movement
( )Neck stiffness

Mid-Back:
( )Mid-back pain
( )Muscle spasms

Low Back:
( )Low back pain
( )Low back stiffness
( )Muscle spasms

Shoulders:
( )Pain in shoulder(s)
( )Pain between shoulder blades

Arms & Hands:
( )Pain in arms/hands
( )Tingling/numbness in arms/hands
( )Swelling in arms/hands

Hips, Legs & Feet:
( )Pain in hips, legs or feet
( )Tingling/Numbness in hips, legs or feet
( )Swelling in feet

Please check all present symptoms with:
( )Skin, hair, nails
( )Eyes/Vision
( )Ears/Hearing
( )Nose/Sinuses
( )Mouth/Throat
( )Respiratory/Breathing
( )Digestion/Elimination
( )Urination
( )Allergies
( )Nervousness
( )Irritability
( )Fatigue
( )Depression
( )Panic attacks
( )Problems sleeping
( )Generally feel run-down

Women Only:
( )Painful/Irregular periods
( )Taking birth control medication
# of pregnancies _____
# of deliveries_____

Social History:
( )Smoking
( )Other tobacco use
( )Alcohol use
( )Coffee or tea

Diet is:
( )Balanced
( )Not balanced

Sleep is:
( )Sufficient
( )Not sufficient
I average _____ hours of sleep per night

Exercise/Recreation is:
( )Sufficient
( )Not sufficient
Please list type and frequency of current exercise:_____

General stress is:
( )Severe
( )High
( )Moderate
( )Minimal
( )None

Favorite Hobby:

Health Goals:

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Financial Office Policy

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.

2. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.

3. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured /Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).

4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.

5. As a patient, it is your responsibility to take care of the co-payment (usually 20%) and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.

6. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

7. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.

8. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

9. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.

10. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.

11. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.

12. If you change insurance companies or employers, you agree to provide this office with current information immediately.

13. This office accepts, Mastercard, Visa, Cash and Personal Checks.

14. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department *prior to seeing the Doctor*.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

Patient Consent for Use & Disclosure of Protected Health Information

With my consent, Advance Upper Cervical Chiropractic may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO).

With my consent, Advance Upper Cervical Chiropractic may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Advance Upper Cervical Chiropractic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I give my consent for the Doctor to contact other co-managing healthcare providers and inform them of relevant information regarding care, pending verbal authorization by me.

By signing this form, I am consenting to Advance Upper Cervical Chiropractic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advance Upper Cervical Chiropractic may decline to provide treatment to me.

_____ _____

Signature Print Name

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature Date

Authorization to Pay/Release Is Granted to: Advance Upper Cervical Chiropractic

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Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. 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 may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

_____

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

Patient Name (printed) _____ Date_____

Patient Signature (or Guardian) _____ Relationship to patient _____

Witness Signature (office staff)_____ Date _____

Informed Consent Cone Beam CT Scan

1. **A CBCT scan, also known as Cone Beam Computerized Tomography**, is an x-ray technique that produces 3D images of your neck that allows visualization of internal bony structures in cross section rather than 2D standard x-ray imaging.

2. **Advantages of a CBCT Scan over conventional x-rays:** A conventional x-ray of your cervical spine limits your practitioner to a two-dimensional or 2D visualization. Benefits of CBCT scans include: A. Higher accuracy when planning specific adjustments; B. Greater chance for diagnosing conditions that can be missed on conventional x-ray films; C. Greater chance of providing images and information which may result in the patient avoiding unnecessary treatment; D. The CBCT scan enhances your practitioner's ability to see what needs to be done before treatment is started. E. Quicker and less invasive compared with traditional x-ray imaging.

3. **Radiation:** CBCT scans, like conventional x-rays, expose you to radiation. The dose of radiation used for CBCT examinations are carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is less than a traditional cervical x-ray series. However, all radiation exposure is linked with a slightly higher risk of developing cancer. But the advantages of the CBCT scan outweigh this disadvantage.

4. **Pregnancy:** Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell your practitioner if you are pregnant or planning to become pregnant.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE TO ACCEPT THE RISKS AND ADVANGAGES NOTED. I, _____being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have the Doctors at Advance Upper Cervical Chiropractic perform a CBCT scan.

_____ _____

Patient Signature Date

_____ _____

Witness (Office Staff) Date

Females Only:

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_____ _____

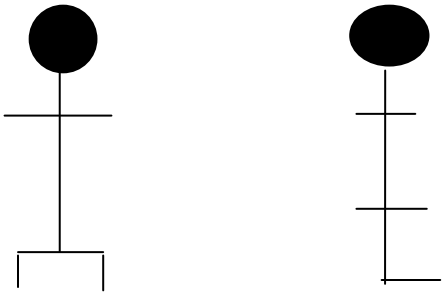
Patient Signature Date

_____ _____

Witness (Office Staff) Date

Exam (For Doctor Use Only)

Posture:



CROM:

LR /80

RR /80

LLF /45

RLF /45

FL /55

EXT /75

O/N:

SLC:

AC:

PLC:

DER:

PALP: L R

BP: