



## Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.

Thank you and welcome to HealthSource!

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### Patient Information

First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Gender: \_\_M\_\_ F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_S\_\_ M \_\_W\_\_ D Job Title: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Children: Names and Ages: \_\_\_\_\_

### Insurance Information

Name of person on the insurance card: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of employer: \_\_\_\_\_

Employer phone number: \_\_\_\_\_ City: \_\_\_\_\_

Person responsible for this account: \_\_\_\_\_

### Additional Information

In case of emergency, whom should we contact? \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

May we send your Family Physician updates on your progress? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is your primary complaint? \_\_\_\_\_

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Is this worker's compensation? \_\_\_\_\_ Is this personal injury? \_\_\_\_\_



## Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Name: Philicia Black Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

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*Name of Patient or Legal Representative*

*Date*

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*Signature of Patient or Legal Representative*

*Date*

### Facility Use Only

- Patient has been provided Acknowledgement of Notice of Privacy Practices and has refused to sign.

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*Authorized Staff Signature*

*Date*



## Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

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PATIENT'S/GUARDIAN'S SIGNATURE

INSURED'S SIGNATURE

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INSURANCE COMPANY NAME

DATE

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### LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original. I have read and fully understand this agreement.

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PATIENT'S/GUARDIAN'S SIGNATURE

DATE



## **CANCELLATIONS/LATE ARRIVALS/NO-SHOWS**

Our office doesn't accept cancellations but we will gladly reschedule your appointment. Your healing progress is based on consistent visits.

**Cancellations** - Our office policy requires a 24-hour notice for appointment cancellations or rescheduling. We typically have a waiting list of patients who would like to see the Doctor or Physical Therapist. If you cannot make your appointment, please extend the office and other patients the courtesy of giving ample notice so that someone on the waiting list may be seen during that time.

**Late Arrivals** - If you arrive more than 10 minutes late for your appointment, expect to be rescheduled or to wait for an open spot in that day's schedule. Nobody likes to wait any longer than they have to at the doctor's office. It only takes one person being a few minutes late to cause everyone to have to wait that day.

**No-shows** - We understand that things do come up and we will try to be as accommodating as possible. But please be aware that a \$25 fee will be assessed for no-shows and cancellations without a 24-hour notice.

We recognize that your time is valuable-this will help us stay on schedule and minimize the time you wait for your appointment.

I understand and accept this policy.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**



NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

**Have you RECENTLY noted any of the following (check all that apply)?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> changes in appetite                          | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> pain at night       |
| <input type="checkbox"/> changes in bowel or bladder function         | <input type="checkbox"/> fever/chills/sweats       | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> headaches                 | <input type="checkbox"/> weakness/fatigue    |
| <input type="checkbox"/> difficulty swallowing                        | <input type="checkbox"/> nausea/vomiting           | <input type="checkbox"/> weight loss/gain    |

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> anemia                                 | <input type="checkbox"/> heart disease         | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> asthma                                 | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> cancer (type) _____                    | <input type="checkbox"/> kidney/liver problems | <input type="checkbox"/> stomach ulcers       |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> lung problems         | <input type="checkbox"/> stroke               |
| <input type="checkbox"/> depression                             | <input type="checkbox"/> multiple sclerosis    | <input type="checkbox"/> thyroid problems     |
| <input type="checkbox"/> diabetes                               | <input type="checkbox"/> osteoporosis          | <input type="checkbox"/> epilepsy             |
| <input type="checkbox"/> pacemaker inserted                     | <input type="checkbox"/> HIV                   | <input type="checkbox"/> arthritis            |
| <input type="checkbox"/> other _____                            |  |   |

**During the past month have you been feeling down, depressed or hopeless? YES NO**

**During the past month have you been bothered by having little interest or pleasure in doing things? YES NO**

**Do you smoke? YES NO \_\_\_\_\_ pack/day**

**FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO**

**Please list current medications (QUANTITY & FREQUENCY):**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  
4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_

**Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO**

**ALLERGIES:** \_\_\_\_\_

Are you latex sensitive? YES NO

**PLEASE LIST PAST SURGERIES:**

- |          |            |          |            |
|----------|------------|----------|------------|
| 1. _____ | Year _____ | 2. _____ | Year _____ |
| 3. _____ | Year _____ | 4. _____ | Year _____ |
| 5. _____ | Year _____ | 6. _____ | Year _____ |

**HEIGHT** \_\_\_\_\_

**WEIGHT** \_\_\_\_\_

**FOR DIABETIC PATIENTS only:**

- Hammer toes  
 Xerosis (dry, rough, cracking)

**SHOE SIZE AND WIDTH** \_\_\_\_\_

- Blister/ callus       Bunions       Corns  
 Ingrown Nails

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(office use only) PT initials \_\_\_\_\_ Date \_\_\_\_\_