PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed.

Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health.

Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

____

PATIENT NAME

____

DATE COMPLETED

Patient Information

Name: ______________________________ (Age) ________ Gender: M F

Home Address: ______________________________ Home Phone: ( ) ____________

City, State, Zip: ______________________________ Work Phone: ( ) ____________

Email Address: ______________________________ Cell Phone: ( ) ____________

Birth Date: _____ /_____ /_____ Social Security #: ______ - _____ - ______ Marital Status: S M D W

Occupation: ______________________________ Employer Name: ______________________________

Spouse's Name: ________________ Work Phone: ( ) ________________ Cell Phone: ( ) ____________

Spouse's Employer: ______________________________ Occupation: ______________________________

How were you referred to this office? ______________________________

Purpose For This Visit

Reason for this visit: ______________________________

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: _____ /_____ /_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: ______________________________

**** Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms. ****

When did these symptoms begin? _____ /_____ /_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain: ______________________________

What activities aggravate your symptoms? ______________________________

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: ______________________________

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: ______________________________

Have you been treated for this? ❑ Yes ❑ No When were you last treated? _____ /_____ /_____

Who did you see? ______________________________

What treatment was performed? ______________________________

How did you respond? ______________________________

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who? ______________________________

Reason for visit(s): ______________________________

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis? ________________

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what? ________________ How long were you treated? ________ Last treatment: _____ /_____ /_____

How did you respond? ______________________________

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain: ______________________________

____

____

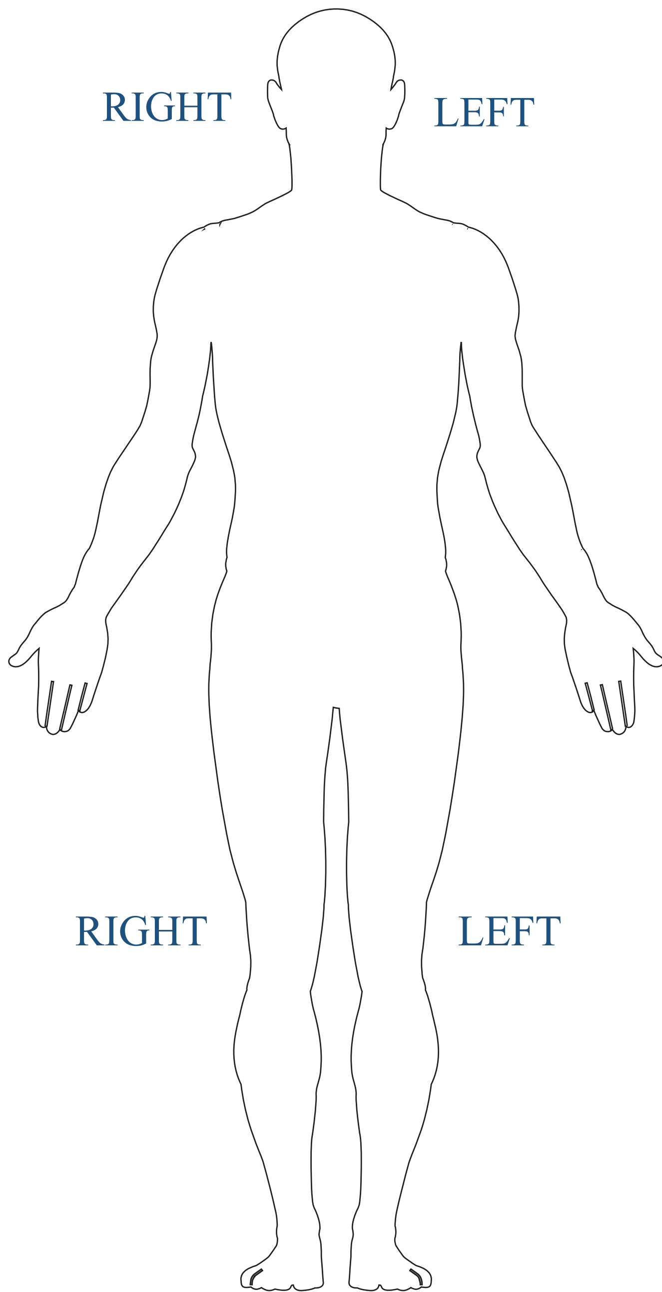
____

2019

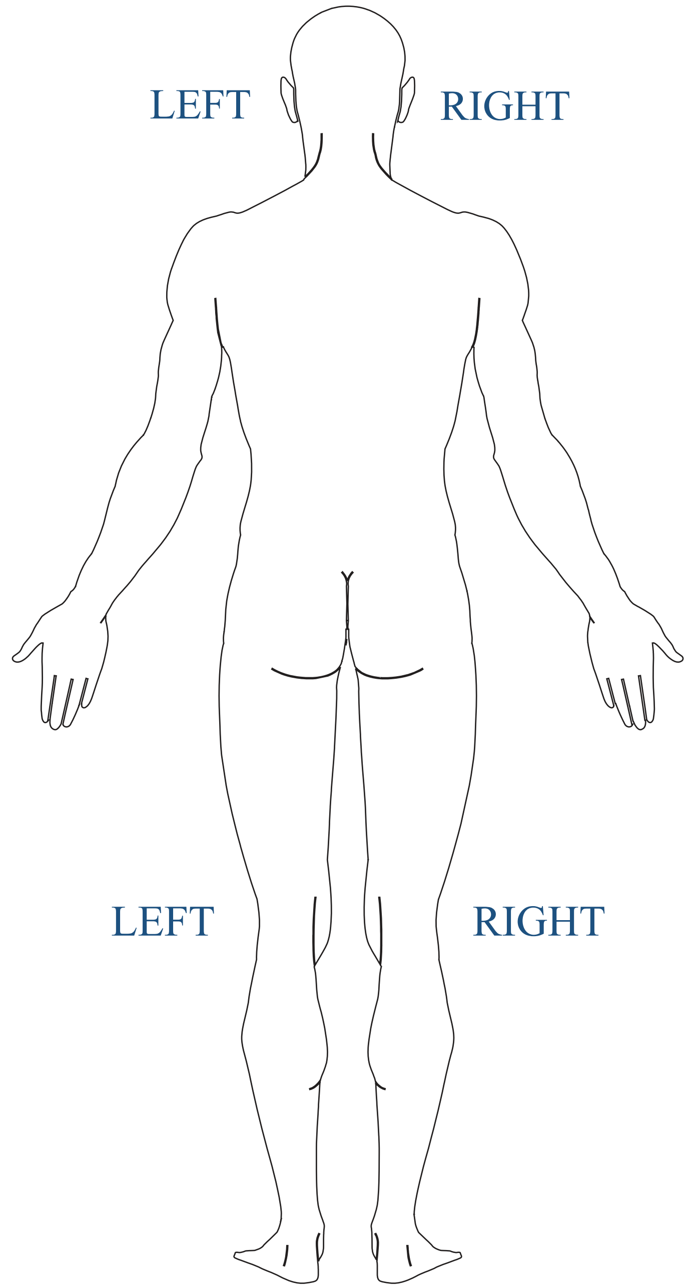
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A	=	ACHE	S	=	STABBING	N	=	NUMBNESS
B	=	BURNING	M	=	SPASMS	T	=	TINGLING
P	=	PINS & NEEDLES	FF	=	STIFFNESS	O	=	OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

____

____

____

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often? ______ day(s) per week; Other: ______

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other: ______

Do you smoke? ❑ Yes ❑ No How much? / How often? ______

Do you drink alcohol? ❑ Yes ❑ No How much? / How often? ______

Do you drink coffee? ❑ Yes ❑ No How much? / How often? ______

Do you take any supplements (i.e. vitamins, minerals, herbs)? ______

If yes, please list: ______

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? **If pain is NOW, please CIRCLE the % frequency, and the number severity.**

Please indicate: (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

____ Headache Pain 100% • 90-75% • 75-50% • 50-25% • 25-5% 1 2 3 4 5 6 7 8 9 10

____ Neck Pain 100% • 90-75% • 75-50% • 50-25% • 25-5% 1 2 3 4 5 6 7 8 9 10

____ Pain Shoulders/Arms/hands 100% • 90-75% • 75-50% • 50-25% • 25-5% 1 2 3 4 5 6 7 8 9 10

____ Numb-tingling: Arms/hands 100% • 90-75% • 75-50% • 50-25% • 25-5% 1 2 3 4 5 6 7 8 9 10

____ Weakness in the grip R / L

____ Hearing disturbances

____ Dizziness

____ Visual disturbances

____ Coldness in hands

____ Thyroid conditions

____ Sinusitis

____ Allergies / Hay fever

____ Recurrent colds / Flu

____ Low Energy / Fatigue

____ TMJ-JAW: Pain / Clicking

Please explain: ______

______

______

______

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? **If pain is NOW, please CIRCLE the % frequency, and the number severity.**

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations

____ Heart Murmurs

____ Tachycardia (racing heart beat)

____ Heart Attacks / Angina

____ Recurrent Lung Infections / Bronchitis

____ Asthma / Wheezing

____ Shortness Of Breath

____ Chest or Rib Pain with breathing 100% • 90-75% • 75-50% • 50-25% • 25-5% 1 2 3 4 5 6 7 8 9 10

Please explain: ______

______

______

______

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.*

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? **If pain is NOW, please CIRCLE the % frequency, and the number severity.**

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

Condition	Frequency	Severity		
____ Mid Back Pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Nausea	____ Diabetes
____ Pain in Ribs / Chest	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Ulcers / Gastritis	____ Hypoglycemia / Hyperglycemia
____ Pain shoulder blades	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Reflux	____ Indigestion / Heartburn

____ Tired / Irritable after eating or when not having eaten for a while

Please explain: ______________________________

____

____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the LUMBAR curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine, may result in many health conditions. Have you experienced any of these symptoms presently or in the past? **If pain is NOW, please CIRCLE the % frequency, and the number severity.**

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

Condition	Frequency	Severity	
____ Lower back pain / SI joint pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Frequent / difficulty urinating
____ Pain: hips / legs / feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Recurrent bladder infections
____ Numbness/tingling in legs/feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Menstrual cramps / irregularities
____ Muscle cramps in legs / feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Constipation / Diarrhea
			____ Coldness: legs / feet
____ Weakness: hips / knees / ankles	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	____ Sexual dysfunction

Please Explain: ______________________________

____

OTHER

Please list any health conditions not mentioned: ______________________________

____

____

Please list any **MEDICATIONS** include name, dose, for what condition, and how long you've been taking it):

____

____

____

Please list any **SURGERIES** (include type of surgery and date it was performed): ______________________________

____

____

____

Please list **FOUR** of your most important 20-30 year health goals:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: ____

____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______ /______ /______

Patient's Signature ______________________________ Date ______ /______ /______

Authorization of Care

I authorize and agree to allow the doctor and/or designated Ex-STATIC staff to take x-rays and work with my spine and/or joints of my body, through the use of spinal adjustments, rehabilitative exercises, and traction for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature ______________________________ Date ______ /______ /______

Patient's Name Printed ______________________________

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded ____________________ County, State of Guardianship ____________________

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature ______________________________ Date ______ /______ /______

In Case of Emergency

Name ______________________________ Relationship ____________________

Work Phone ( ) ____________________

Home Phone ( ) ____________________

Cell Phone ( ) ____________________

Insurance Disclosure

We may accept assignment of PIP (crash / personal injury insurance) and MEDICARE insurance benefits only.

By signing This policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefits is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full and in advance at the time of service. In NO CASE will an assignment alleviate you of your obligation for payment of services rendered.

Your insurance plan is CONTRACT between you and your insurance company. This clinic is NOT a party to that contract and therefore Cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your PIP insurance or MEDICARE insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment.

In the event that we do accept assignment of benefits (such as PIP and MEDICARE) we require that your provide a credit card with authorization to bill that account any balance, or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If the insurance company HAS NOT paid your account in full within 60 days, and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

Itemized Receipts, aka "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office **DOES PARTICIPATE** with most major medical providers (BCBS , AETNA, CIGNA, UNITED HEALTH etc...) and we will make every effort to communicate your financial responsibilities related to insurance costs.

Patient Declaration

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier (PIP and MEDICARE only), this service is strictly a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

SIGNATURE: ____ **DATE:** ______________________________

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of Chiropractic Adjustments (SMT) and other procedures, including various modes of manual therapy, physical therapy, therapeutic stretching, electrotherapies, active exercises, spinal traction, intervertebral disc decompression and diagnostic x-rays, by Ex-Static Chiropractic and /or their personnel. I further understand and am informed that, as in all health care, results are not guaranteed, there is no promise to cure. There are **very slight risks** to chiropractic, including, but not limited to the following:

~Aggravating and / or temporary increases in pain symptoms or muscle spasms
~Rare cases of rib fractures, muscle and ligament sprains or strains following manual adjustments.
~There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. These artery injuries are associated with stroke, sometimes with neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote, and have been found to be an equal risk with medical care. (1-6)
~There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment.

Chiropractic treatment, including SMT, have been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective and safe treatment for musculoskeletal pain. I acknowledge that I have discussed, or have had the opportunity to discuss, the nature and purpose of Chiropractic treatment in general and my treatment in particular, as well as the contents of this Consent Form.

I do not expect my doctor(s) to be able to anticipate and explain every risk or complication and I wish to rely on my doctor(s) to exercise professional judgment during the course of the procedure which the doctor feels as the time, based upon the facts then known, and is in my best interest.

Our clinic operates an Open Rehab Bay. Therefore there will be times where your treatment program may have you in contact with other patients. If there is ever a time where you wish to speak with your doctor in private, we will always accommodate your request. Rest assured, your patient information will always remain confidential.

This consent applies to all my present & future care with Ex-Static Chiropractic.

Patient Signature ____ Date ______________

1) Cassidy, J David DC, PhD; Boyle, Eleanor PhD; Côté, Pierre DC, PhD; He, Yaohua MD, PhD; Hogg-Johnson, Sheilah PhD; Silver, Frank L. MD; Bondy, Susan J. PhD; Risk of Vertebrobasilar Stroke and Chiropractic Care: Results of a Population-Based Case-Control and Case-Crossover Study; Spine; Volume 33(4S), February 15, 2008 pp. S176-S183.
2) Murphy DR; Current understanding of the relationship between cervical manipulation and stroke: what does it mean for the chiropractic profession?; Chiropractic and Osteopathy; 2010 Aug 3;18:22.
3) Choi S, Boyle E,CoteP, Cassidy JD. A population-based case-series of Ontario patients who develop a vertebrobasilar artery stroke after seeing a chiropractor. J Manipulative Physiol Ther 2011; 34(1): 15-22.
4) Smith DL, Cramer GC; LETTER TO THE EDITOR: Spinal Manipulation is Not an Emerging Risk Factor for Stroke Nor is it Major Head/Neck Trauma. Don't Just Read the Abstract!; The Open Neurology Journal, 2011, 5, 46-47
5) Dunning JR, Cleland JA, Waldrop MA, Arnot C, Young I, Turner M, Sigurdsson G; Upper Cervical and Upper Thoracic Thrust Manipulation Versus Nonthrust Mobilization in Patients With Mechanical Neck Pain: A Multicenter Randomized Clinical Trial; Journal of Orthopaedic & Sports Physical Therapy; January 2012; Volume 42; Number 1; pp. 5-18.
6) Herzog W, Leonard TR, Symons B, Tang C, Wuest S; Vertebral artery strains during high-speed, low amplitude cervical spinal manipulation; Journal of Electromyography and Kinesiology; April 5, 2012 [epub].

HIPAA PATIENT CONSENT FORM- EX-STATIC CHIROPRACTIC

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: ______________________________
Printed Name – Patient or Representative

____
Signature Date

Relationship to Patient
(if other than patient) ______________________________

Witness: ______________________________
Printed Name – Clinic Representative

____
Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason:______________________________

Financial Agreement

Please remember that insurance is considered a method of REIMBURSING THE PATIENT for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances 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 DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, EX-STATIC CHIROPRACTIC 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.

______________________________ ____________________________
PATIENT SIGNATURE INSURED'S SIGNATURE

____
DATE

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 health care benefits coverage with the above captioned, and hereby assign and convey directly to EX-STATIC CHIROPRACTIC 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 the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and 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 the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care 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 health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care 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 as valid as the original. I have read and fully understand this agreement.

__________________________________ ____________________________
Signature of Insured/Guardian Date