- All patients will be subject to a missed appointment fee of $**50.00** if our office is not notified within 4 hours of the scheduled appointment. Effective: 03/10/2017

- **Financial Policy Regarding Payment -** My staff will do their best to assist you in obtaining information about your carrier's Chiropractic coverage.**NO INSURANCE COMPANY GUARANTEES COVERAGE OVER THE PHONE. The office of Schafer Chiropractic is not responsible for "verified" information received over the phone.** As the patient, I understand and agree, that whether or not I have insurance and/or referral, or whether Schafer Chiropractic is/is not a provider of my network and/or I have an approved treatment plan, and whether or not my insurance company determines my care medically necessary, that **I am ultimately responsible for full payment of any and all services received in this office.** I will pay any insurance co-payment, deductible and expenses not covered by my member contact as service us rendered or denied,
- **Informed Consent for Examination and Treatment -** I (we) herby consent to the performance of examination and treatment on myself or my child, by the licensed doctor of chiropractic, medical doctors, and/or licensed physical therapists who may be employed or engaged in practice in this clinic. I have had an opportunity to discuss with the doctor(s) or other clinics personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon the facts known that is in my best interest. I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which include rarely, but not limited to accept and consent to the risk associated with the care that I am about to receive. I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intended this consent to cover procedures prescribed for my condition and for any future conditions for which I seek treatment. **Female Patients:** By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor s pregnancy suspected or confirmed at this particular time. Date of last menstrual period_________.
- Protecting the privacy of your personal health information is important to us. The notice describes how information about you may be used and disclosed and how you can get access to thus information. Please review carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law informant activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosure of protected health information are limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days. A request to do so may require a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that are accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clear visible location in our office. You may file a complaint about privacy violations by contacting our Office manager.

By signing I agree with all items listed above.

Patient Name/Signature____________________________________ Date____________

Text/Email Reminders – As a courtesy our office provides patients with different ways to be reminded of appointments and/or ways to cancel/reschedule appointments. Please pick from the following:

O Text O Email O None

Provider:

O AT&T O Verizon O US Cellular O Sprint O Metro PCS O Boost Mobile O Virgin Mobile
O Cricket O T-Mobile

Reminder Time: O 2 Hrs. before appt. O 1 day before

As a courtesy to our valued patients we will gladly submit insurance claims on your behalf. Any credits from insurance will either be added to patient accounts or refunded back to the patient. Payment in full is expected the day of service and must be made before leaving the office after each visit. Thank you for your consideration in this matter.

Signed_______________________Date__________

Welcome

Patient Information

Date____

SS/HIC/Patient ID #_________________________________

Patient Last Name__________________________________

Patient First Name_________________________________

Address____

City_______________State__________ Zip Code_________

Email____

Sex ◯ Male ◯ Female Age_____________________

Birthdate____

◯ Married ◯ Widowed ◯ Single ◯ Divorced ◯ Minor

Home Phone (_____)________________________________

Cell Phone (_____)_________________________________

Occupation____

Patient Employer/School____________________________

Employer/School Address____________________________

Employer/School Phone (____)_______________________

Spouse's Name________________Birthdate___________

Whom may we thank for referring you?_____________________________________

In Case of Emergency, Contact

First Name___________________________________

Last Name____________________________________

Relationship__________________________________

Cell Phone (____)_____________________________

Home Phone (____) ____________________________

Work Phone (____)_____________________________

Accident Information

Is the condition due to an accident? ◯ Yes ◯ No

Date of the Accident____________________________

Type of Accident ◯ Auto ◯ Work ◯ Home ◯ Other

To whom have you made a report of your accident?

◯ Auto Insurance ◯ Employer ◯ Worker Comp. ◯ Other

Attorney Name (if applicable)____

____

Patient Condition

Reason for Visit____________________________________ When did your symptoms appear?______________________

Is this condition progressively getting worse? ◯ Yes ◯ No ◯ Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) ___________

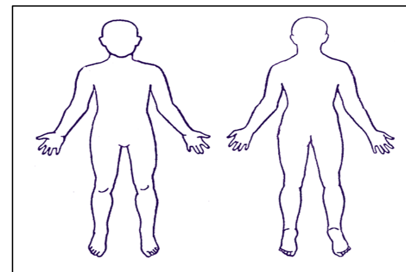
Type of pain: ◯ Sharp ◯ dull ◯ throbbing ◯ Numbness ◯ aching ◯ shooting ◯ burning ◯ Tingling ◯ Cramps ◯ Stiffness ◯ Swelling ◯ Other ______________________

How often do you have this pain? _____________________ Is it constant or does it come and go? ____________________

Does it interfere with your ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

Activities or movements that are painful to perform

◯ Sitting ◯ Lying down ◯ Walking ◯ Bending



Mark an X on the picture where you continue to have pain, numbness, or tingling.

Doctors Comments____

____

Health History

What treatment have you already received for you condition(s)? ◯ Surgery ◯ Physical Therapy ◯ Chiropractic

◯ None ◯ Other ______________________________

Name and Address of your current primary doctor ______________________________

Date of Last: Physical Exam_______ Spinal X-ray______ Blood Test________ Spinal Exam _________

Chest X-ray _______ Urine Test_______ Dental X-ray ______ MRI, CT- Scan, Bone Scan __________________________

Please mark the circle if any of these currently or in the past apply to you:

◯ AIDS/ HIV	◯ Diabetes	◯ Liver Disease	◯ Rheumatoid Arthritis
◯ Alcoholism	◯ Emphysema	◯ Measles	◯ Rheumatic Fever
◯ Allergy Shots	◯ Epilepsy	◯ Migraine Headaches	◯ Scarlet Fever
◯ Anemia	◯ Fractures	◯ Miscarriage	◯ Sexually Transmitted Disease
◯ Anorexia	◯ Glaucoma	◯ Mononucleosis	◯ Stroke
◯ Appendicitis	◯ Goiter	◯ Multiple Sclerosis	◯ Suicide Attempt
◯ Arthritis	◯ Gonorrhea	◯ Mumps	◯ Thyroid Problems
◯ Asthma	◯ Gout	◯ Osteoporosis	◯ Tonsillitis
◯ Bleeding Disorders	◯ Heart Disease	◯ Pace Maker	◯ Tuberculosis
◯ Breast Lump	◯ Hepatitis	◯ Parkinson's disease	◯ Tumors, Growths
◯ Bronchitis	◯ Hernia	◯ Pinched Nerve	◯ Typhoid Fever
◯ Bulimia	◯ Herniated Disk	◯ Pneumonia	◯ Ulcers
◯ Cancer	◯ Herpes	◯ Polio	◯ Vaginal Infections
◯ Cataracts	◯ High Blood Pressure	◯ Prostate Problem	◯ Whooping Cough
◯ Chemical Dependency	◯ High Cholesterol	◯ Prosthesis	◯ Other__________________
◯ Chicken Pox	◯ Kidney Disease	◯ Psychiatric Care	______________________

Exercise

◯ None
◯ Moderate
◯ Daily
◯ Heavy

Work Activity

◯ Sitting
◯ Standing
◯ Light Labor
◯ Heavy Labor

Habits

◯ Smoking Packs/ Day___________
◯ Alcohol Drinks/ Week_________
◯ Coffee/ Caffeine Drinks Cups/ Day ___________
◯ High Stress Level Reason_____________

Are You Pregnant? ◯ Yes ◯ No

Injuries/ Surgeries

Falls______________________________ Date_____________

Head Injuries__________________________ Date_____________

Broken Bones__________________________Date_____________

Dislocations___________________________Date_____________

Surgeries_____________________________Date_____________

Medications/ Allergies/ Vitamins

____
____
____
____
____

Pharmacy Name______________________________

Pharmacy Number (_____)______________________