Teays Valley Chiropractic, P.L.L.C
3 Station Pl.
Hurricane, WV 25526
PH: (304) 757-7266

First Name: _____ **Last Name:** _____ **M.I.** _____

Gender: Circle One: M F **Date of Birth:** ___/___/___ **SSN:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Email:** _____

Consent to text reminders: Y or N-Please circle

Employer Name: _____ **Occupation:** _____

Spouse/Responsible Party or Guardian:

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Phone#** _____

Please provide the updated insurance information to front desk!

If this injury is a result of a car wreck or employment, please check one option:
Personal Injury: _____ **Date of injury:** _____ **Employment** _____
If one of the above option is checked, you will be required to provide further information.

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.
I hereby authorize and release the doctor to administer treatment, physical examinations, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case: and I further authorize him to disclose all or part of my patient record to any person or corporation which is or may be liable under a contract to the clinic, or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance co., worker's compensation carriers, welfare funds or employers.

X _____ **Date:** _____
Signature of patient or person acting on patients behalf

Turn Over ->

FILL OUT ENTIRE PAGE!!!!

DATE:_____PATIENT NAME:_____DOB:_____

MAIN PROBLEM:
What pain causes you to come to the office?_____

What caused the pain?_____

When did the pain start?_____How long does the pain last?_____

How bad is the pain?(Circle one-1=mild-10=intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain: Cramping, Aching, Dull, Sharp, Shooting, Stiffness, Tingling, Throbbing, Burning, Pressure like, Numbness

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does the pain travel to any other area?_____
What makes this pain better?_____
What makes the pain worse?_____
What else have you done to treat this pain?_____

Other Problem:
What other pain do you have?_____
What caused this pain?_____
When did this pain start?_____How long does this pain last?_____
How bad is this pain(CIRCLE ONE-1=MILD-10=intense pain) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Circle the word or words that best describe the pain: Cramping, Aching, Dull, Sharp, Shooting, Stiffness, Tingling, Numbness, Throbbing, Burning, Pressure Like

Does this pain travel to any other area? _____
What makes this pain better?_____
What else have you done to treat this pain?_____
Surgeries/Hospitalizations/Injuries: List below:

_____

_____

Current Medications/Purpose: (List All)

_____

_____

PLEASE LET US KNOW IF YOU HAVE GONE TO PT OR ANOTHER CHIROPRACTOR THIS YEAR

Review of Symptoms

The following list of conditions may seem unrelated to your current health problem. However, these problems may influence your overall diagnosis, treatment plan and whether your case is accepted in this office.

Name:_____ DATE:_____

CHECK ANY OF FOLLOWING DISEASES YOU HAVE HAD:

__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Cancer
__Cataracts
__Chicken Pox
__Diabetes
__Diptheria
__Eczema
__Epilepsy
__Emphysema
__Fractures
__Headaches
__Glaucoma
__Goiter
__Gout
__Heart Disease
__Hepatitis
__Herniated Disk
__Influenza
__Kidney Disease
__Liver Disease
__Lumbago
__Malaria
__Measles
__Mental Disorder
__Migraines
__Mumps
__Osteoporosis
__Pleurisy
__Pneumonia
__Polio
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Small Pox
__Stroke
__Suicide Attempt
__Tonsilitis
__Tuberculosis
__Tumors
__Typhoid Fever
__Ulcers
__Venereal Infection
__Whooping Cough

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST
CIRCLE ANY CURRENT HEALTH PROBLEMS

MUSCUO-SKELETAL

__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Arm Pain

__Walking Problems
__Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM

__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/Depression
__Fainting

GENERAL

__Allergies
__Loss of Sleep
__Fever
__Headaches

__Gas/Bloating After Meals
__Heartburn
__Black/Bloody Stools
__Joint Pain/Stiffness

GENITO-URINARY

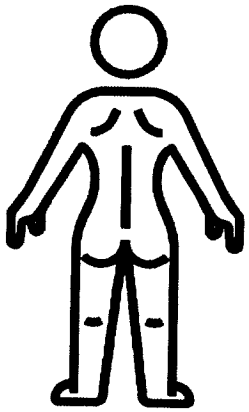
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine

CARDIO/RESPIRATORY

__Chest Pain
__Shortness of breath
__Blood Pressure Problems
__Irregular Heartbeat
__Lung Problems/Congestion
__Ankle Swelling
__Varicose Vein

EENT

__Vision Problems
__Dental problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose



Please outline on the diagram the area of your discomfort.

TURN OVER--→

Review of Systems (Con't)

GASTRO-INTESTINAL

__Poor/excessive appetite

__Excessive thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Gall Bladder Trouble
__Weight Gain/Loss
__Abdominal Pain

__Menstrual Irregularity
__Menstrual Cramping
__Vaginal Pain/ Infections
__Breast Pain/Lumps
__Genital Herpes
__Currently Pregnant

OTHER HISTORY

Do you smoke? __YES __No If yes, how many per day?_____
Do your drink? __YES __NO If yes, How much?_____
Are your pregnant?__YES __NO Date of last physical exam_____
List Past Illnesses_____

FAMILY HISTORY

Please circle any that apply to your family history

HIGH BLOOD PRESSURE:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
HEART DISEASE:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
STROKE:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
DIABETES:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
ARTHRITIS:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
SCOLOSIS:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT
CANCER:				
MOM	DAD	BROTHER	SISTER	GRANDPARENT

WHICH TYPE: _____

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Teays Valley Chiropractic:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course treatment for my present condition (s) and for and future condition (s) for which I seek treatment.

Sign only after you understand and agree to the above.

x_____ _____
Signature of Patient DATE

x_____ _____
Signature of Representative DATE
(if patient is a minor or is handicapped)

Turn Over ->

Massage Therapy Agreement

Due to an increased number of appointments scheduled with our massage therapists, Teays Valley Chiropractic has adopted the following policy:

1. We must receive notice of cancelling at least 24 hours before your appointment. We try to be as helpful as possible if you need to cancel or reschedule.

2. Failure to cancel your appointment in the appropriate time frame, you will be charged $30.

3. This also applies to no show appointments. **NO EXCEPTIONS FOR THIS CHARGE.** This is paid directly to the massage therapist for her time. Additionally, in the event that you are 15 minutes late for your appointment, Teays Valley Chiropractic reserves the right to fill your remaining scheduled time.

4. If you have been a no show more than twice, we have the right to not schedule you future massage appointments.

Thank you for your consideration and cooperation in this matter. Your signature below indicates you have read and agree to the above stated policy.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

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PATIENT FINANCIAL RESPONSIBILITY

You are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay and deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.

Patients that do have health insurance:

We will check your benefits as a courtesy but what your insurance may tell us might differ when we actually bill them
YOU are responsible to check your chiropractic benefits prior to your visit.

Patients that do not have health insurance:
Payment is due on the day of service.

We will strive to work out s feasible payment option for anyone who is need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent.

I authorize payment of insurance benefits directly to Teays Valley Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understood, and agree with the terms on this page.

_____ _____

Signature of responsible party (Parent of Legal Guardian) *DATE*

Turn over->>

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Authorization and HIPAA Compliance Patient Consent Form

I have reviewed the information provided for the chiropractor and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and helpful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company, lawyer, or representative to pay the chiropractor or chiropractic group all benefits for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: • Protected health information may be disclosed or used for treatment, payment, or healthcare operations. • The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. • The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed: _____

This consent was signed by (PRINT NAME HERE): _____
Signature: _____ **Date:** _____
Witness: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT