Adult Chiropractic Health Questionnaire

Welcome to our office! It is well known that families who maintain strong healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Name _____ Home Phone _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

Birth date _____ Age _____ SS# _____ Male_____ Female_____

Occupation _____ Employer _____

Employer's Address_____ Phone # _____

Marital Status: M W Sep. D Sin. Spouse Name _____ No. of Children _____

Spouse's Employer _____

Spouse's Birth date: _____ E-mail Address _____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____

☐ Telephone Call ☐ Yellow Pages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ ☐ Never

3. When was your last complete spinal examination including x-rays? _____ ☐ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ YES ☐ NO _____

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐ YES ☐ NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.

1. _____ 2. _____ 3. _____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

_____

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ YES ☐ NO Date of Incident _____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐ YES ☐ NO

13. Have you ever been diagnosed with cancer? ☐ YES ☐ NO

Type _____ Year _____

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? ☐ YES ☐ NO

MEDICARE AUTHORIZATION

Do you have Medicare insurance? _____ Medicare Identification # _____

Medicare Supplemental Insurance? _____Supplemental Identification #_____

Do you have Blue Shield? _____ Blue Shield Identification #_____

AUTHORIZATION AND RELEASE: I authorize payment of Medicare insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Authorization Signature_____ Date_____

All of the above patient information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____

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ONLY For patients under the age of 18 years old:

Consent to Treatment of Minor Child

I hereby authorize McCormick Chiropractic of Elverson, PA and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my _____(indicate relationship of child), _____(name of child).

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian Name:_____ Phone: _____ Cell:_____

Name of Parent/Guardian *responsible* for Patient's Account: _____

Address (if different from address of patient): _____

Phone: _____ Cell:_____

PATIENT HIPAA NOTICE

McCormick Chiropractic
83 W Main Street, Ste 4, Elverson
610-286-7000

YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice informs you of how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also informs you of your rights regarding your PHI. For DETAILED privacy notice: Please ask our Front desk for our HIPAA binder.

YOUR RIGHTS

You have the right to:Revoke any Authorization, in writing, at any time.

- Request restrictions on certain use and/or disclosure of your PHI as provided by law. To request restrictions, you must submit a written request to the Practice's Privacy Officer
- Restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the Practice unless a law requires us to share that information.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer.
- Receive an accounting of non-routine disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer.
- Receive a paper copy of this *Notice of Privacy Practices* from the Practice upon request.
- To file a complaint with the Practice, please contact the Practice's Privacy Officer. All complaints must be in writing. To obtain more information, or have your questions about your rights answered, please contact the Practice's Privacy Officer.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- **Care** – In order to provide care to you, the Practice will provide your PHI to those health care professionals directly involved in your care.
- **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

PATIENT HIPAA NOTICE

- **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care.
- **Business associates that perform functions on our behalf** – We may use billing and collection services. Our business associates, including credit card applications and billing and collection services may disclose necessary PHI to their vendors

Authorization is not required for: The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. **Business Associate** – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.
3. **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
5. **Abuse, Neglect or Domestic Violence, or Judicial proceedings or Law enforcement** – To a government authority, if the Practice is required by law to make such disclosure.
6. **Workers' Compensation** – If you are involved in a Workers' compensation claim.
7. **Disclosure**- Clover Chiropractic has my authorization to disclose Medical Records or information to:

   Name:_____

   Phone:_____ **Email**:_____

APPOINTMENT REMINDER: If the Practice provides appointment reminders or makes contact for the purpose of providing information about treatment alternatives or other health related benefits or services, to preserve patient privacy and adhere to guideline, the Practice has implemented written policies and procedures regarding this subject which enables the patient to identify specific and approved contact information. Note that this information can be reviewed or changed at any time upon request of the patient. Text messaging reminders, if permitted by the patient, may only be performed by the Practice through secure or encrypted texting services, unless the patient has signed an authorization permitting unencrypted messages.

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health.

_____

Patient

_____

Signature Date

_____

INFORMED CONSENT

Clover Chiropractic SCM, P.C. DBA: McCormick Chiropractic of Elverson

Name: _____,

Please read the entire document prior to signing it. It is important that you understand the information contained herein. For clarity, please ask questions of the Doctor before you sign.

The nature of the chiropractic adjustment:

The primary treatment we use as Doctors of Chiropractic is *spinal manipulative therapy*. We will use that procedure to treat you. We may use hands or a mechanical instrument upon the body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, and basic neurological testing.

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during treatment. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain or sprains 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 serious complications including stroke. (refer to next paragraph). Some patients will feel some **stiffness and soreness following the first few days of treatment**. We will make every reasonable effort during the examination to screen for contraindications to care; however, *if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.*

The probability of those risks occurring

Fractures are *rare* occurrences and generally result from some underlying weakness of the bone, which we check for during your initial examination and medical consult. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly *rare* and are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

I, _____ on date of _____, have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor and have had my questions answered to my satisfaction. By signing I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or the patient's best interest, for whom I am legally responsible) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.