**Advanced Family Chiropractic**

**Notice of Privacy Policies**

**Acknowledgment Form**

Effective Date: This notice is in effect as of February 16th, 2012

Acknowledgment:

I acknowledge that I have been offered to review a copy of my ADVANCED FAMILY CHIROPRATIC’S Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Individual (print) Signature of Individual Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Personal Representative, Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

Advanced Family Chiropractic

I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Advanced Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Advanced Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees, if legal action becomes necessary, to collect this account. I authorize Advanced Family Chiropractic to obtain a credit report, if necessary.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or Spouse’s Signature who authorized care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY, PLEASE NOTIFY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICARE PATIENTS ONLY

Medicare pays for services rendered on a medical necessity basis. They may or may not pay up to 36 visits per calendar year for chiropractic care. This is decided after they have reviewed your case. Therefore, we would like you to be aware that they will be basing your care on a medical necessity basis.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above paragraph and understand that if Medicare does not find my case a medical necessity, I know that I am responsible for all services rendered.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCED FAMILY CHIROPRACTIC**

**Dr. Robert Berry**

**CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT)**

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

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status S M W D Children\_\_\_\_\_\_\_\_**

**Whom may we thank for your referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been to a chiropractor before? Y N If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List your chief complaints in order of severity:**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list other doctors consulted for these conditions:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this an injury? Y N If yes, is it work related?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you reported it to your employer? Y N Is it related to an automobile accident? Y N**

**If this is an accident, please fill out the appropriate report form, which will be provided to you and**

**RETURN IT ON YOUR NEXT VISIT.**

**ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.**

**The fee paid for treatment X-Rays is for analysis only. If x-rays are removed from the office the**

**Patient MUST sign a release form.**

***Terms of Acceptance***

When a patient seeks chiropractic care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal---to eliminate misalignments within the spinal column which interfere with the expression of the body’s innate wisdom. It is important that each patient understands both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

**Adjustment:** The specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

**Health:** A state of ***optimal*** physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual finds, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

**OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and fully understand the above statements. All questions regarding the doctor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

***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, if necessary. I have been advised that x-ray can be hazardous to an unborn child.**

**Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

***Consent to Evaluate and Adjust a Minor Child***

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, being parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

Advanced Family Chiropractic Office Policies

Welcome to our office! The following is a list of our office policies. The purpose of these policies is to allow us to better serve you and to achieve the best results in the shortest amount of time. It is our experience that those patients who adhere to these policies achieve the best results.

**Rescheduling Appointments:**

We have a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the desired results. Thus, if you need to change times or days of your appointments, please do so within three (3) days. Please give twenty-four (24) hours notice (if possible) so that other patients may be seen during the time slot.

**Re-examinations and Progress Evaluations**:

Re-examinations and re- evaluations take place every twelfth visit. These examinations will enable us to measure your improvement and determine the necessity for further treatment. At the end of 90 days, we x-ray.

**Consultations:**

Dr. Bob is more than happy to discuss any concerns or problems that you may be having. Please schedule a consultation time with the front desk CA to enable the doctor give you his full attention to avoid having other patients wait.

**Payment of Bills:**

We expect you to honor the financial arrangements that you make with our office if you find that you cannot fulfill your agreement with us, please advise us immediately so that new arrangements can be made. If the arrangement is terminated or suspended, a balance will be due reflecting the retail fee for services previously rendered.

**Cash Payments:**

Full payment is expected on your first visit. A cash balance may not at any time exceed $150.00. Please arrange a payment schedule.

**Family Chiropractic introduction:**

During the first week of your care, your entire family is entitled to complimentary subluxation evaluations.

Date\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAIN DIAGRAM

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TODAYS DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING “PAIN DIAGRAM” BY USING LETTERS AT THE LEFT TO

INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (P) PATIENT’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TINGLING (T)

NUMBNESS (N)

BURNING (B)

STIFFNESS (S)

