# NORTHERN
Chiropractic and Wellness

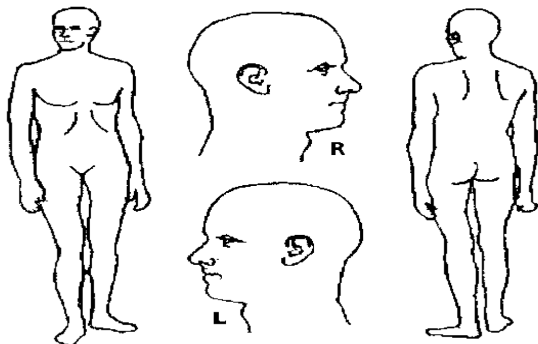
## About You

| Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |
| Cell Phone:<br>Home Phone: | | |
| E-mail Address: | | |
| Date of Birth: | Age: | |
| Marital Status: S M | Number of Children: | |
| Employer : | | |
| Spouse's Name: | Spouse's Employer: | |

## Reason for this visit

| What is your *primary* reason for this visit: |
|---|
| Is this appointment related to one of the following:<br>______Long term discomfort _____Injury at work<br>______Auto accident _____Other |
| When did the problem(s) begin: |

### Mark areas of pain with an "X"




## Current condition(s)

*Instructions: Please circle the health concerns or conditions you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and nerve functions.*

C1 C2 C3 C4 C5 C6 C7 T1

- HEADACHES
- MIGRAINES
- DIZZINESS
- SINUS PROBLEMS
- ALLERGIES
- FATIGUE
- HEAD COLDS
- VISION PROBLEMS
- DIFFICULTY CONCENTRATING
- HEARINGPROBLEMS

- SORE THROAT
- STIFF NECK
- RADIATING ARM PAIN
- HAND/FINGER NUMBNESS
- ASTHMA
- ALLERGIES
- HIGH BLOOD PRESSURE
- HEART CONDITIONS

T2 T3 T4 T5 T6 T7 T8 T9

- MIDDLE BACK PAIN
- CONGESTION
- DIFFICULTY BREATHING
- BRONCHITIS
- PNEUMONIA
- GALLBLADDER CONDITONS
- STOMACH PROBLEMS
- ULCERS
- GASTRITIS
- KIDNEY PROBLEMS

L1 L2 L3 L4 L5 S A C R A L

- CONSTIPATION
- COLITIS
- DIARRHEA
- GAS PAIN
- IRRITABLE BOWEL
- BLADDER PROBLEMS
- MENSTRUAL PROBLEMS
- LOW BACK PAIN
- PAIN OR NUMBNESS IN LEGS
- REPRODUCTIVE ISSUES

## NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. 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 enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

*I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.*

| PATIENT'S NAME (PLEASE PRINT): | RELATIONSHIP TO PATIENT: |
|---|---|
| SIGNATURE: | DATE: |

Regarding: Chiropractic Adjustments, modalities, and therapeutic Procedures:

*I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per two million adjustments.*

*Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Northern Chiropractic and Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor(s). After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.*

Patient or authorized person's signature ______________________ Date ___________________

**PAYMENT AGREEMENT /USE OF INSURANCE AUTHORIZATION**

*I hereby authorize the Doctors of Northern Chiropractic and Wellness to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Northern Chiropractic and Wellness will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.*

*I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Northern Chiropractic and Wellness, LLC for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Northern Chiropractic and Wellness will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Northern Chiropractic and Wellness, LLC will be credited to my account upon receipt.*

| Signature: | Date: |
|---|---|
| Guardian or Spouse Authorizing Care's Signature: | Date: |