DixonFamilyChiropractic
THE LEADING EDGE OF CHIROPRACTIC

Confidential Patient Health Record Todays Date ________/_______/________

How did you hear about us? ______________________________Person'sName_______________________________

Person Information

Title: ☐Mr. ☐Mrs. ☐Ms.

Last: ___________________________________ First: ___________________________Middle Initial: ________

Suffix: ☐Jr. ☐Sr. ☐II ☐III

Birth Date: _______/_______/________ Age: ________ Sex: ☐Male ☐Female

Address____ Apt. # ______________

City: ______________________________ State: ___________ Zip: __________________

Cell Phone: (______) ______-______ Home Phone: (____) _______-_______

Work Phone: (____) _____-________ Email Address: ____________________________________

Emergency Contact

Last Name: ______________________________ First: ____________________________ Middle Initial: _____

Relationship: ☐Spouse ☐Relative ☐Friend ☐Other____________________

Cell Phone: (____) _______-_______ Home Phone: (____) ______-________

Employment Information

Business Name: ____

Phone: (______) ________-__________ Ext: _____________

Occupation/ Job Title: ______________________________ Job Description: ______________________________

Main Complaint

☐ Low Back ☐Neck ☐Shoulder ☐Mid Back

☐Other: ____

Woman Only

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and Dixon Family Chiropractic has my permission to perform an X-Ray evaluation. I understand the risk of taking an X-Ray to an unborn child. **☐ I AM PREGNANT**

Date of last menstrual period___________________________________ Initials_____________________________

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FINANCIAL POLICY

Dear Patient,

Thank you for choosing Dixon Chiropractic, PLLC for your healthcare needs. Please take a moment to review our financial policy below.

Please note that your primary health insurance, and/or no-fault personal injury protection benefits (when applicable) are not a guarantee of payment for treatment rendered, and you, the patient, are responsible to verify your own benefits as well. Your exact benefit amount is determined after we bill your insurance carrier and actually receive an explanation of benefits from them. You will receive the same explanation from your insurance company describing your exact dollar amount owed.

You are required to pay the co-payment/deductible at the time of your office visit each time you are seen. If you are not prepared to pay that amount, you should reschedule your visit unless other arrangements have been made with the office manager. You will be billed for all unpaid charges. If you do not understand your statement balance, please call the office for an explanation of charges on the statement.

If you are seeking treatment at our facility for an Auto or Work related accident which occurred on or about _____________ (date), by signing this policy, you, the patient, give a lien for the total amount outstanding to Dixon Chiropractic, PLLC on any settlement, claim, law suit, judgment, or verdict as a result of aforementioned accident, and authorize and instruct your attorney, and/or insurance company, to pay directly to Dixon Chiropractic, PLLC all such sums as may be due and owing to Dixon Chiropractic, PLLC for services rendered to me, and to withhold such sums from such settlement, law suit, claim, judgment, or verdict, as may be necessary to fully protect Dixon Chiropractic, PLLC. Please note that this lien will supersede any attorney lien.

I specifically agree that disbursement of any proceeds to me shall not take place unless and until Dixon Chiropractic, PLLC has been paid in full for treatment rendered.

I fully read and understand that I am personally and fully responsible to Dixon Chiropractic, PLLC for all chiropractic/medical bills submitted by Dixon Chiropractic, PLLC for services rendered to me and this agreement is made solely for Dixon Chiropractic, PLLC's additional protection and in consideration awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said charges for treatment.

Medicare Patients Only: Your adjustments are the only covered service under Medicare. Any other services will not be covered by your insurance. These excluded services include Examinations, X-rays, Therapies and the Wellwave. Medicare expects you (or your supplemental insurance), to pay for all other excluded services you receive.

Patient Signature: ____________________________________ Date: _________________________

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NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting Dr. Patrick Dixon, D.C.

●We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, aid with your diagnosis or treatment from another provider or radiologist.
●We may use your health information for health and safety reasons, court hearings and fillings, reporting to law officials and for reporting victim's abuse.
●We may call you by name in reception area when the doctor is ready to see you. A postcard may be mailed to you at the address provided by you.
●When telephoning your home, we may leave a message with whomever answers or on your answering machine.
●We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy right have been violated.

Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read, understand and agree to

NOTICE OF PRIVACY PRACTICES.

AUTHORIZATION

I certify that I'm the patient or legal guardian of above mentioned. I have read/understand that the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurances submissions. I understand and agree that all services rendered to me will be charged to me and I'm responsible for timely payment of such services I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

____ ___________________
Name of Patient: (Please Print) Date

____

Signature:
(or Parent/Guardian)

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Terms of Acceptance

Procedures

Consultation- No charge, this is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. **Exam**- after your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic and chiropractic examination will be recommended.

X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays to be taken

Report of Findings- (Included in the cost of the examination) This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best approach to improve your health.

Treatments- include spinal and extra spinal adjustments, Wellwave (ACT), curve restoration traction, core muscle training, rehabilitation, posture correction exercises, custom orthotics, nutritional recommendations and supplements.

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. Our facility has one main objective, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: a misalignment of one of more of the 24 vertebras 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.

Adjustment: a specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures to achieve maximum correction of this dysfunction.

Open Adjusting Area Our office does use an "Open" adjusting area. If in need of a private adjusting area, please inform the front desk of availability.

PAYMENT POLICY

- Payment is expected at the time of service, unless some other arrangement has been made between you and the billing staff
- Health/Auto/Workers Comp Insurance
  1. Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
  2. We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement
  3. If your policy has a deductible feature, it is due at the time of service.
  4. We will do our very best to answer any questions you may have regarding your insurance.
- **Medicare Patients Only:** Your adjustments are the only covered service under Medicare. Any other services will not be covered by your insurance. These excluded services include Examinations, X-rays, Therapies and the Wellwave. Medicare expects you (or your supplemental insurance), to pay for all other excluded services you receive.
- There will be a $25 charge on any returned checks.

By signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE

____ ___________________________

Patient Signature (Parent/Guardian) Date

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INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, examination, traction, and if necessary diagnostic x-rays, on me by the Doctor of Chiropractic and/or by other office or clinic personal.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISK OCCURING

The risk of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, as been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED

- *Over the counter analgesics*. The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as extended convalescent period in significant number cases

RISKS OF REMAINING UNTREATED

Can further reduce ranges in motion and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make rehabilitation more difficult.

CONSENT

I acknowledge I have discussed or have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to be by my chiropractor. I intend this consent to apply to all present and future chiropractic care.

____ ____________________________

Patient Signature (Parent/Guardian) Date