Westmoreland Chiropractic Sports Associates

Informed Consent for Care

Print Full Name: _____ Date:_____

Chiropractic Manipulation, massage therapy, and traction-based therapy with decompression as an goal of treatment are the services delivered at this clinic. These are not methods for preventing, diagnosing, treating, healing or curing symptoms, disease or medical conditions of any kind. I understand that should I receive chiropractic manipulation, exercise advice or nutritional advice, there may be temporary side-effects such as fatigue and possible aggravation of the symptoms presented after a treatment.

I also understand that being well fed and hydrated is necessary to facilitate benefits from our services and it is my responsibility to see that I have adequate nourishment each day.

I understand the practitioners are Chiropractors and Massage Therapists, and there is no medical care provided of any kind. No cures are guaranteed. I understand that the initial visit includes a history, exam and testing as directed in order to evaluate if the services of the Center are right for me and determine if I am eligible for our services.

I understand that Gregory Wilson, D.C., I.C.C.S.P will see me my first visit upon request, depending on the reason for appointment. Dr. Wilson performs chiropractic adjustments and physiotherapy procedures including spinal decompression, therapeutic exercises, and Class IV laser.

I understand that once nutritional supplements, essential oils, and any other product are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless Dr. Wilson determines that the order was filled incorrectly.

Should I opt to take advantage of it, I understand that the discounted, flat rate Pre-Pay Package offered is a non-refundable program and may not be altered, shared, transferred or combined with any other promotional special or discount. I understand that any unused portion of a Pre-Pay Package upon discharge from the above centers may be applied to product purchases or may be moved to another service (excluding complimentary visits that were issued as part of package rate) or is forfeited. I understand that I am free to pay in full, visit by visit and that any prepaid package program is only an incentive to move through my program to achieve my goals.

I understand that Westmoreland Chiropractic Sports Associate is paid in cash at the time of service (or in advance with discounted, pre-pay programs) for product purchases. Postdated payments are accepted when proper arrangements are made.

I have read and understand the above terms of service. **Patient Signature _____**

CONSENT TO TREAT A MINOR (Under 18 years old)

I, _____, do hereby request this center to evaluate and perform services for my _____ named_____, age _____, and consent on his or her behalf. I am a legal guardian of this child. I understand that while this child is in the center, he/she is to be with me at all times and may not be left alone, unsupervised or in the care of staff or other clients. I have read and agree to the Center's above terms.

Guardian Signature _____ Date _____

Staff Member _____ Date _____

PATIENT INFORMATION

NAME: _____ AGE: _____ DATE OF BIRTH: ____/____/_____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_ _____

PHONE: (____)_____ *EMAIL: _____

*CELL PHONE: (____)_____*CELL PHONE CARRIER: _____

*an email or cell phone with carrier (i.e. AT&T, Verizon) is **required** to send reminders of your future appointments

MARRIED: YES____ NO_____ NUMBER OF CHILDREN (if applicable): _____

SPOUSE'S NAME: _____BIRTH DATE:___/___/___

IN CASE OF EMERGENCY, NOTIFY (other than spouse): _____

ADDRESS: _____ STATE:_____ ZIP:_____

PHONE: (_____)_____RELATIONSHIP: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

WHAT CONDITION(S) BROUGHT YOU TO OUR OFFICE:_____

_____

MEDICAL DOCTOR: _____ PHONE: (_____)_____

The following points are important that you read and agree to in order for you to become a patient at our clinic.

- All services rendered will be considered **cash** until your insurance is verified.
- If you are unable to keep your appointment, we require that you call ahead to cancel so that someone else, if needed, can be put in your appointed time.
- Payment for services rendered that day are due before you leave unless other financial arrangements have been made.

By signing this, I acknowledge that I have read and agree to the above office policies.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____

Patient Name: _____ Today's Date:_____
(Printed)

CANCELLATION and NO-SHOW POLICY

The following is our policy regarding cancellations and no-shows. We take this subject seriously at our office, because it can make a difference between whether you succeed in your treatment or not. Dr. Wilson will prescribe a set of frequency of treatments. Showing up as scheduled for these appointments is your most important job. Other than that, all you need to do is follow Dr. Wilson's instructions and we will be able to help achieve your goals in treatment.

* We would like to have a 24 hr. notice in an event that you need to cancel your appointment. We understand there may be things come up that keep you from making your appointment time. But if there are multiple appointments that have been cancelled, then you will be assessed a **$20 charge**. This will not be paid by insurance or any 3rd party. This will be your responsibility.

** There is a **$30 charge** for anyone who 'no-shows' for their appointment. A 'no-show' appointment is one where no call was made to reschedule your visit. This will be paid by you personally before you will be seen by Dr. Wilson. This not only includes adjustment visits, but any massage or decompression therapy treatments that were missed without notice.

When a patient does not show up for their appointment, three people are affected. You, because you don't get the treatment you need; Dr. Wilson who now has space in his schedule since the time was reserved for you; and another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard so we can help you return to full function. We look forward to working with you.

RECORD-KEEPING POLICY

Files, charts, and all patient information will be kept in our office for seven (7) years. After that time, patient records may be destroyed in a manner that protects patient confidentiality, such as by shredding or incineration.

I have read and understand the above statements, and understand these are our office policies.

_____
Patient's Signature

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. Thank you.

Name_____ Date_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

O - Occasional
F - Frequent
C – Constant

GENERAL

- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Loss of Sleep
- ☐☐☐ Loss of Weight
- ☐☐☐ Nervousness
- ☐☐☐ Sweats
- ☐☐☐ Tremors

MUSCLE & JOINT

- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Hernia
- ☐☐☐ Low Back Pain
- ☐☐☐ Neck Pain/Stiffness
- ☐☐☐ Pain between shoulders

Pain or Numbness in:

- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hands
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet
- ☐☐☐ Painful Tail Bone
- ☐☐☐ Poor Posture
- ☐☐☐ Sciatica
- ☐☐☐ Spinal Curvature
- ☐☐☐ Swollen Joints

GASTRO-INTESTINAL

- ☐☐☐ Belching/Gas
- ☐☐☐ Colitis
- ☐☐☐ Colon Trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult Digesting
- ☐☐☐ Excessive Hunger
- ☐☐☐ Gall Bladder Trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Jaundice
- ☐☐☐ Liver Trouble
- ☐☐☐ Nausea
- ☐☐☐ Pain over Stomach
- ☐☐☐ Poor Appetite
- ☐☐☐ Vomiting

EYES, EARS, NOSE, & THROAT

- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Earache
- ☐☐☐ Ear Infections
- ☐☐☐ Ringing in ears
- ☐☐☐ Enlarged Glands
- ☐☐☐ Enlarged Thyroid
- ☐☐☐ Eye Pain
- ☐☐☐ Failing Vision
- ☐☐☐ Gum Trouble
- ☐☐☐ Nasal Obstruction
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus Infections
- ☐☐☐ Sore Throat
- ☐☐☐ Tonsillitis

CARDIOVASCULAR

- ☐☐☐ Hardening of arteries
- ☐☐☐ High Blood Pressure
- ☐☐☐ Low Blood Pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid Heart Beat
- ☐☐☐ Slow Heart Beat
- ☐☐☐ Swelling of ankles

RESPIRATORY

- ☐☐☐ Chest Pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficult breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Wheezing

SKIN

- ☐☐☐ Boils
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Hives or allergies
- ☐☐☐ Itching

GENITO-URINARY

- ☐☐☐ Bed-wetting
- ☐☐☐ Blood in Urine
- ☐☐☐ Frequent Urination
- ☐☐☐ Loss of Kidney Control
- ☐☐☐ Kidney Stones
- ☐☐☐ Painful Urination
- ☐☐☐ Prostate trouble

WOMEN ONLY

- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excessive Menstrual flow
- ☐☐☐ Irregular cycles
- ☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

☐ Alcoholism	☐ Cold Sores	☐ Goiter	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart Disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic Fever	☐ Venereal Diseases

PLEASE PRINT

Age of mattress: _____ yrs. ☐ Firm ☐ Soft ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports

Have you ever had any mental or emotional disorders: ☐ No ☐ Yes When_____

HAVE YOU EVER:	**YES**	**NO**	**DESCRIBE:**
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine of nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything?	☐	☐	_____

DO YOU:			
Now take vitamins or minerals?	☐	☐	_____
Think you may need vitamins or minerals?	☐	☐	_____
Have an allergy to any medications?	☐	☐	_____

List any medications that you are taking: _____
_____

DATES OF LAST:	**Within 6 months**	**6-18 months**	**Over 18 months**	**Never**
Spinal Examination	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Chest X-Ray	☐	☐	☐	☐
Spinal X-Ray	☐	☐	☐	☐
Dental X-Ray	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Smoking Tobacco	☐	☐	☐	☐
Illegal Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME:_____ PHONE:_____

ADDRESS:_____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign the consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosures of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Signature

_____ _____

Signature Date