Northwest Chiropractic Center

OFFICE PROCEDURE & PATIENT INTRODUCTION

(Please read carefully before completing)

This clinic specializes in structural and nerve related conditions, weight loss and a holistic approach to body-health relationships. This clinic recognizes that the mind, spinal structure, nerve interference and nutritional factors all play a significant role in maintaining a healthy body. Therefore, examinations may consist of x-rays, blood profiles, urinalysis, orthopedic and neurological tests, etc. depending on what is necessary. The minimum fee for preliminary examinations is $40. More detailed or specific examinations may be needed in complex, chronic or complicated cases to make confirmation.

Patients are accepted by this clinic in 3 ways:

1.) *Acute Conditions* (not complex or chronic in nature, with no involved exam findings) - patient is treated on a visit by visit basis or unit of therapy charge - regular office calls.

2.) *Chronic or Complex Conditions* (conditions which have not responded to other forms of treatment or are shown by examination to be complex and require greater attention) - patient is accepted on a stabilization fee basis where one fee covers the course of treatment. Conditions are graded from Grade 1 to Grade 6, depending on their severity and on what actually needs to be done. If examination reveals a Grade 6 determination, the possibility of a neuro-surgical consultation or other health practitioner must be considered.

3.) *Nutritional Deficiencies/Weight Loss* - generally dealt with in chronic conditions, but can be dealt with on a case basis.

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in all portions of the form.

Legal Name: ______________________________ S.S. #: ______________________________

Address: ______________________________ City: ____________ State: _____ Zip: ________

Email: ______________________________

Home Phone: ___________________________ Work/Cell Phone: _________________________

Date of Birth: _______________ Age: _____ Sex (circle): Male Female Marital Status (circle): S M D W

Occupation: __________________ Employed by: __________________ Phone: ______________

Spouse's Name: _______________ Employed by: __________________ Phone: ______________

Name of Relative Not Living With You: ____________________________ Phone: ______________

Is your visit due to an accident (automobile or work-related)? Yes No Are you a Medicare Patient? Yes No

Emergency Contact: ______________________________ Phone: _________________________

**How did you become aware of our office? ______________________________

PRESENT COMPLAINT: ______________________________

How long has this been bothering you? ______________________________

Describe symptoms: ______________________________

____

Please rate your major symptoms: Mild Moderate Severe
Are your symptoms: Getting Better Getting Worse Staying the Same
What type of care do you desire?

1.) Temporary Relief
2.) General Stabilization
3.) Specific correction or stabilization, if possible (optimum health care)

How would you classify your condition?

1.) Minor
2.) Involved
3.) Fairly severe and progressively getting worse
4.) Serious and would like to know cause and correction

MEDICAL HISTORY:

Are you allergic to any medication? Yes No If yes, what? ______________________________
Are you taking any medications? Yes No If yes, please list: ______________________________
____
____

Have you been treated by a medical physician for any condition in the last year? Yes No

1. If yes, name of physician: ____________________ Reason for visit: ____________________

   Address of physician: ____

2. If yes, name of physician: ____________________ Reason for visit: ____________________

   Address of physician: ____

Please list any operations and/or date of hospitalizations that you have had and approximate dates:

1. ______________________________ Date: ________________ Dr: ______________
2. ______________________________ Date: ________________ Dr: ______________
3. ______________________________ Date: ________________ Dr: ______________
4. ______________________________ Date: ________________ Dr: ______________

Do you wear orthotic shoe inserts? Yes No If yes, what type? ______________________________
Female Patients: Are you pregnant? Yes No If yes, when is your due date? ____________________
If no, ending date of last menstrual period? ______________

Do you:
Smoke: Yes No If yes, what amount per day? ________
Drink: Yes No If yes, please choose: Sometimes Frequently Regularly
Exercise: Yes No If yes, please choose: Sometimes Frequently Regularly

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are solely my responsibility, despite any insurance plan, legal involvement, or settlement.

Patient’s Signature: ______________________________ Date: __________

Parent or Guardian Name Printed: ______________________________

Parent or Guardian Signature: ______________________________ Date: __________

Northwest Chiropractic Center

HIPPA PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request at the front desk.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By my signature below, I acknowledge that I have had the opportunity to review the Northwest Chiropractic Center's Notice of Privacy Practices.

____

Print Patient's Name

____

Signature of Patient or Patient's Representative

____

Dated Signed

____

(name and relationship) has permission to receive information regarding my records.

____

(name and relationship) has permission to receive information regarding my records.

PATIENT FILM REPORT

Did you bring in the following?

(Please check appropriate& fill out appropriate choices.)

❒ X-RAY: *Date Taken* ___________

Where Taken/Dr. Name ______________________________

❒ MRI: *Date Taken* ____________

*Where Taken/Dr. Name*______________________________

❒ Other: ____

Informed Consent To Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments and Care, and/or Axial Decompression Treatment

I hereby request and consent to the performance of: physical examinations and evaluations and performance of any tests or X-rays required to be performed to diagnose my condition(s), of chiropractic adjustments, and other chiropractic procedures, including various modes of physical therapy, of Axial Decompression, on me (or on the patient named below, for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of Axial Decompression, chiropractic adjustments and other procedures, and I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

____

Print Patient's Name

____

Signature of Patient or Patient's Representative

____

Dated Signed

Name and address of clinic/office:

Northwest Chiropractic Center
Richard L. Briggs, D.C.
5728 Frantz Rd.
Dublin, Ohio 43016