r·f·c
Renaissance
Family Chiropractic

DEMOGRAPHICS

Name: _____
(Last Name) (First Name) (Middle Initial)

Address: _____

Apt/Ste: _____ City: _____ State: _____ Zipcode: _____

Contact Number: _____

Email: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Patient Employer/School: _____

Occupation: _____

SSN#: _____-_____-_____

☐ Married ☐ Widowed ☐ Single ☐ Domestic Partnership
☐ Divorced ☐ Separated ☐ Minor

Emergency Contact Name: _____

Relation? _____

Emergency Contact Phone Number: _____

Who may we thank for referring you? _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident?
☐ Auto Insurance Company ☐ Employer ☐ Worker Comp. ☐ Other: _____

Attorney Name (if applicable): _____ Contact Number: _____

HEALTH HISTORY

Please circle if any of the following apply:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia
Anorexia	Anxiety	Appendicitis	Arthritis
Asthma	Althlete's Foot	Bleeding Disorders	Bone/Joint Disease
Bronchitis	Bulimia	Cancer	Cataracts
Chemical Dependency	Chicken Pox	Chronic Pain	Depression
Diabetes	Emphysema	Epilepsy	Fractures
Gluacoma	Goiter	Gonorrhea	Gout
Heart Disease	Hepatitis	Hernia	Herniated Disk
Herpes	High Blood Pressure	High Cholesterol	Kidney Disease
Liver Disease	Lupus	Measles	Migraine Headaches
Miscarriage	Mononucleosis	Multiple Sclerosis	Mumps
Osteoporosis	Pacemaker	Paralysis	Parkinson's Disease
Pinched Nerve	Pneumonia	Polio	Prostate Problem
Prosthesis	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever
Scarlet Fever	Shingles	STD/STV	Spinal Problems
Stroke	Suicide Attempt	Tendanitus	Thyroid Problems
Tonsillitis	Tuberculosis	Tumors/Growths	Typhoid Fever
Ulcers	Vaginal Infections	Whooping Cough	Other: _____

Allergies/Sensitivities: _____

Medications: _____

Past Injuries/Surgeries: _____

PATIENT CONDITION

Reason for visit:
☐ Chiropractic ☐ **M**assage ☐ Both

When did symptoms appear? _____

How often? _____

Does it interfere with your:
☐ Work ☐ Sleep ☐ Routine ☐ Recreation

Which are painful to perform:
☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

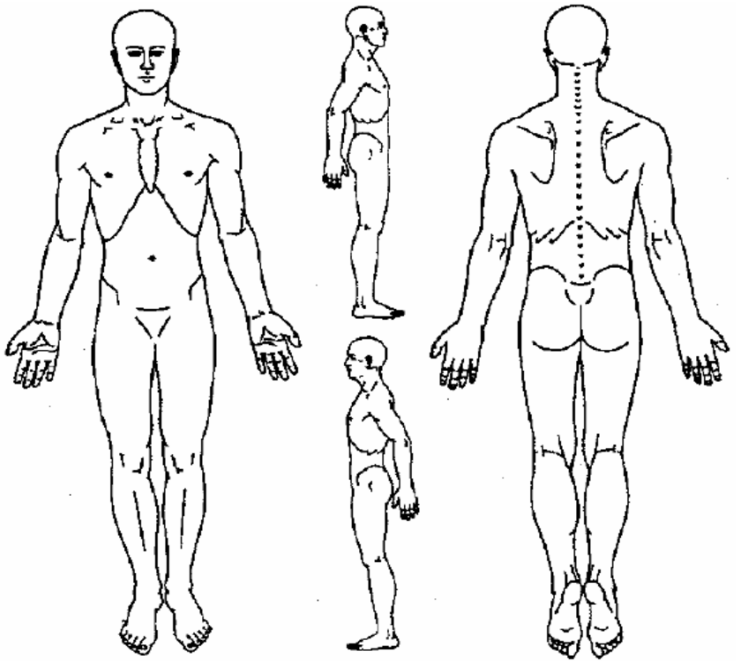
Treaments Received:
☐ **M**edications ☐ Surgery ☐ **P**hysical **T**herapy
☐ Chiropractic ☐ **M**assage ☐ **O**ther: _____

Are you pregnant?
☐ **Y**es ☐ **N**o Due Date: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



RENAISSANCE FAMILY CHIROPRACTIC

Policies & Procedures

Appointments: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we cannot predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore, it is absolutely necessary that you keep your scheduled appointments. If you need to change and appointment, please call at least 24 hours in advance to reschedule your appointment. We will do all that we can to accomodate you. ***For Massage Appointments Only - If you fail to cancel with 24 hours notice, there will be a $50 late cancellation fee applied to your account.***

Daily Visit Procedure: Each time you arrive for your adjustment, sign in on the Ipad tablet and have a seat in the lobby until you are directed to "the hot seat" (scanning chair in the hallway) Once the Doctor learns your spine, your adjustments will take only a few minutes and will be very focused. It may be necessary for you to rest after an adjustment has been made. The lenght of your resting time may vary and will be determined at the time of your adjustment.

Analysis/Examinations/Treatment: During your Initial Intensive Care, you will receive several examinations to monitor your level of spinal correction. All the findings from your initial visit will be retested - plan on spending aproximately 30 minutes on these days. At the end of your Initial Program of Care, you will receive recommendations for additional carer to help you stay as healthy as possible.

As part of the analysis, examination and treatment, you are consenting to the following procedures (***Initial each procedure you are consenting to):***

___ Spinal Adjustment Therapy	___ Orthopedic Testing	___Muscle Strength Testing
___ Range of Motion Testing	___ Postural Analysis	___Vital Signs
___ Radiographic Studies	___ Cold Therapy	___ Palpation
___ Basic Neurological Testing		

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation. However, if during the course of a Chiropractic examination, we encounter Non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a Health Care Provider that specializes in that area.

Payment: We will bill directly to your insurance if your policy covers Chiropractic Care or Massage Therapy. Any Coinsurance or Copayments estimated by your insurance to us will be collected at the time of service. You are responsible for your portion of insurance payments along with anything that is denied by your insurance. We offer several different methods of payment and are happy to work out payment options with you.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept Chiropractic Care (and/or) Massage Therapy on this basis.

_____ _____

(Patient or Guardian's Signature) *(Today's Date)*

Notice of HIPAA Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review carefully***

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. When you receive care from us, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operation. Examples of how we use your information include:

Health Care Operations: We use your health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties, and make plans to better serve our patients.

To use your health information for other than the above uses requires your signed authorization.

There are limited situations when we are permitted or required to disclose health information without your signed consent. These situations include:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drug problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- To reduce and prevent a serious threat to public health and safety.

We are required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make the new privacy practices effective with all the information we maintain. You may request a copy of any notice from our Privacy Officer.

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restrictions.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances we may deny you access to some portion of your health information and you may request a review of the denial.
- Request amendments or additions to your health record.
- Request an accounting of certain disclosures of your health information made by us.

All of the above request must be made in writing through our Privacy Officer.

I, _____, acknowledge that I was provided information regarding my HIPAA rights and that I have read (or had the opportunity to read if I so chose) and understand the above statements.

_____ _____

(Signature of Patient or Guardian) *(Today's Date)*