KNOWLES CHIROPRACTIC OFFICE

Patient Contact Information

About the Patient			
Patient's Full Name		Today's Date	
Address	City	State	Zip
Home Phone	May We Leave a Message? YES NO		
Cell Phone	Email Address		
Circle One: Single Married Widowed Divorced Separated	Patient's Social Security #	Patient's Date of Birth	
Nearest Relative Not Living With Patient	Phone	Cell Phone	
Address	City	State	Zip
Patient Was Referred By:			

Emergency Contact Name	Phone	Cell Phone

Patient's Employer		Work Phone	
Address	City	State	Zip
Patient's Occupation	If Applicable, Ages of Patient's Children		

The Following is Required for Payment Processing			
Name of Patient's Insurance			
Name of the Primary Insured Person			
How is the Primary Insured Person Related to the Patient?			
If Married: Spouse's Full Name		Spouse's Cell Phone	
Spouse's Employer		Employer's Phone	
Employer's Address	City	State	Zip
Spouse's Occupation	Spouse's Social Security #	Spouse's Date of Birth	

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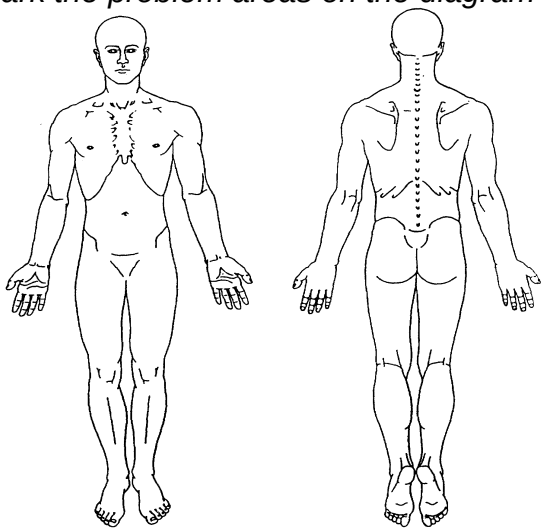
Patient Health Information

Current Health Complaint

Patient's Name: _____ *Pease mark the problem areas on the diagram*



What are the main reasons you are seeking care?

_____

What is the pain like? (circle all that apply)

Sharp Burning Dull Shooting Deep Throbbing Tingling

When did the pain begin? _____

How did this pain begin? _____

The pain is getting: better same worse

Have you had this pain before? Yes No

What makes your condition worse? _____

What makes it better? _____

Is this condition related to: Auto Accident Work Injury Illness

Have you sought medical treatment, surgery, or medication for this complaint? Yes No

If yes, please list: _____

Please mark on the scales below how the pain affects different personal and work activities.

Level of Pain

No Pain ⟷ Extreme Pain

Walking

No Effect ⟷ Very Limited

Sitting

No Effect ⟷ Cannot Sit

Lifting

No Effect ⟷ Unable to Lift

Bending

No Effect ⟷ Cannot Bend

Work Duties

No Effect ⟷ Very Limited

Patient's Health History

Significant Illnesses or Diseases _____

Surgeries _____

Medications You are Currently Taking _____

Previous Accidents or Broken Bones _____

Allergies _____ Do You Use: Tobacco Alcohol Caffeine Drugs

Significant Health Problems or Causes of Death in Family _____

FEMALES: # of Pregnancies _____ Are you currently pregnant? Yes No

Have you had Chiropractic Treatment Before? Yes No

Additional Conditions: *Circle any that apply*

Loss of Bowel or Bladder Control	Recent Unexplained Weight Change	Past or Present Cancer
Unable to Maintain Balance	3 months or more of Steroid Medication	History of Stroke or Aneurysm

I have read the above information and certify it to be true and correct to the best of my knowledge.

_____ _____

Signature of Patient or Parent/Guardian of Patient Date

KNOWLES CHIROPRACTIC OFFICE
Informed Consent Form

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with most medical treatments or other treatments, medications, and procedures given for the same symptoms. You should note:

a) While rare, some patients may experience short-term soreness, aching, swelling, or aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These are not evidence of failure of treatment;

b) Some equipment used in physical therapy and chiropractic treatment generate heat. Due to differing skin tolerances, either heat or ice modalities can irritate or cause minor burns to the skin. The result is a temporary increase in skin pain, and possibly some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms;

d) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

e) Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments, and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this office. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

Informed Consent for Treatment
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 in particular (including spinal adjustment) as well as the contents of this Consent. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.
Patient's Full Name Today's Date
Patient's Signature
If Applicable, Parent/Guardian's Signature Authorizing Treatment

KNOWLES CHIROPRACTIC OFFICE

Financial Agreement Form

This is a statement of our billing and payment policies.
It is required that you read and sign this prior to any treatment.

To Patients Not Using Insurance:

Full payment is expected at the time of service

A Receipt of Service and Payment will be provided upon your request

To Patients Using A Preferred Provider Insurance:

As a service to you, we will bill your insurance directly

You must provide us with a current insurance card

All Co-Pays are due at the time of service

You are responsible to pay in full any services that are denied coverage, applied to deductibles, or are not covered by your insurance

Assignment of Benefits

I authorize my insurance benefits to be paid directly to KNOWLES CHIROPRACTIC OFFICE. I understand and agree that all services rendered to me, or to a minor in my custody, are charge to me directly, and that I am personally responsible for their payment in full. I also understand that if I suspend or terminate treatment, any fees for services rendered will be immediately due and payable.

To All Patients

You assume financial responsibility for all services rendered, regardless of whether insurance or settlements are involved

By signing as a parent or guardian, you assume all financial responsibility for services rendered to the minor

There are additional charges for After Hours, Holiday, and Urgent Care services

We reserve the right to charge $25 for missed appointments or cancellations with less than 24-hour notice. This fee is not covered by your insurance, and must be paid before any additional services are rendered.

We Accept CASH CHECKS VISA MasterCard

Patient's Full Name	Today's Date
Signature of Patient or parent/Guardian	

KNOWLES CHIROPRACTIC OFFICE

Privacy/Consent Form

Endorsement for Patient Information Privacy Practices & Policies - HIPAA
Enclosed is our statement of Patient Information Privacy Practices and Policies. By signing this, you are acknowledging that you have received a copy, had an opportunity to read it and ask questions, and understand that those practices and policies will be applied to your health information. As prescribed by HIPAA, it is required that you read and sign this prior to any treatment.
Today's Date
Patient's Signature
If Applicable, Parent/Guardian's Signature Authorizing Treatment

Release of Information Consent
I authorize KNOWLES CHIROPRACTIC OFFICE to release any information from my patient file, including that which was obtained through examination or treatment, to any insurance company, adjuster, or attorney in order to determine benefits or facilitate payment collection.
I authorize KNOWLES CHIROPRACTIC OFFICE to release any information from my patient file, including that which was obtained through examination or treatment, to the following individual(s): **Name** _____ **Name** _____
Today's Date
Patient's Signature
If Applicable, Parent/Guardian's Signature Authorizing Treatment