

# Prater View Chiropractic and Health Clinic

## PERSONAL HISTORY

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female Marital Status:  M  S  D  W  SEP

Social Security \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Race (Circle one): American Indian / Asian / African American / White (Caucasian) / Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic of Latino / Not Hispanic or Latino / Decline to Answer

Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Have you seen a chiropractor before?  Yes  No

Approximately how long were your visits? \_\_\_\_\_

Was that too long or not long enough? \_\_\_\_\_

For office use only

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

## INJURY STATUS

**Reason for today's visit:**  Emergency  New Injury  Old Injury  Chronic

**Did your injury occur during:**  Sports/ Play  Accident  Routine/ Household activity  Other \_\_\_\_\_

**When did your condition/ accident occur?** \_\_\_\_\_ **Where did your injury occur?** \_\_\_\_\_

**Please explain what happened:** \_\_\_\_\_

**How often do you experience symptoms?** (Circle one) Constantly Frequently Occasionally Intermittently

**Describe your symptoms?** (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

**Is your condition getting worse?**  Yes  No  Constant  Comes and goes

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

**My condition is aggravated by:**

- |  |  |   |                                    |  |
|--|--|---|------------------------------------|--|
| <input type="checkbox"/> Standing too long | <input type="checkbox"/> Sitting too long  | <input type="checkbox"/> Driving              | <input type="checkbox"/> Sneezing  | <input type="checkbox"/> Coughing                |
| <input type="checkbox"/> Pulling           | <input type="checkbox"/> Laying on my back | <input type="checkbox"/> Laying on my stomach | <input type="checkbox"/> Bending   | <input type="checkbox"/> Bowel movement          |
| <input type="checkbox"/> Pushing           | <input type="checkbox"/> Twisting          | <input type="checkbox"/> Stooping             | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Lifting over _____ lbs. |

Is your condition interfering with your:  Work  Sleep  Daily Routine? If so, how: \_\_\_\_\_

# CURRENT HEALTH CONDITION(S)

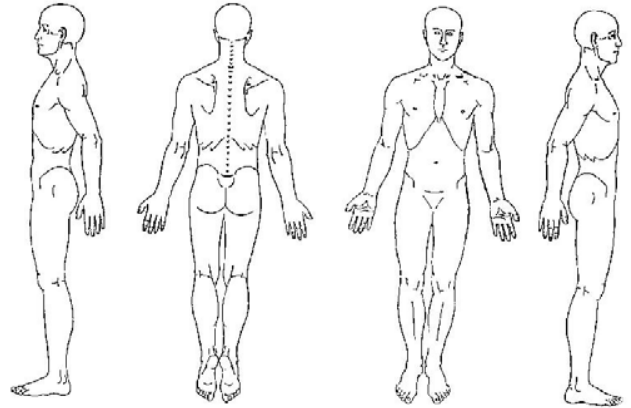
Using the adjacent body charts, please *circle* all affected areas.  
What are your current health condition(s)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you been treated by another physician for this/these condition(s)?

Yes  No If so, please list other Doctors:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



LEFT

BACK

FRONT

RIGHT

### Medication Currently Taking:

Medication Name	Dosage & Frequency

### Medication Allergies:

Medication Name	Reaction	Onset Date

List any surgeries or hospitalizations you have had complete with the month and year for each: \_\_\_\_\_

Do you have or have you had any diseases, medical conditions or procedures? \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Family Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): \_\_\_\_\_

Previous X-rays taken?  Yes  No Areas: \_\_\_\_\_

Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

Are you dieting?  Yes  No Since: \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per day

Do you use tobacco?  Yes  No \_\_\_\_\_ packs per day. How many years have you been using tobacco? \_\_\_\_\_

Do you wear?  Heal lifts  Arch supports  Prescription Orthotics  No If so who recommended them? \_\_\_\_\_

*For women:*

Are you pregnant or nursing?  Yes  No If pregnant, how many weeks? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

**HIPPA PRIVACY**

Prater View Chiropractic and Health Clinic

Darnell Simpson D.C.

Devin Simpson D.C.

118 S. Main St. Suite 400

Thayne, WY 83127

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Phone: 307-883-7246

Fax: 307-883-7247

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessment and physical certifications.

I have received, read and understand your Notice and Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I choice to decline receipt of my clinical summary after every visit. At any time I can request these me emailed to me.

Patient Signature

Date

Parent or Guardian

Date

# Prater View Chiropractic and Health Clinic

118 S. Main St. Suite 400

Thayne, WY 83127

Phone: 307-883-7246

## **Financial Policy**

### **Cost of Services**

	<u>TOS</u>	<u>Personal Insurance</u>
➤ Initial history and exam consult:	\$35.00	\$50.00
➤ Treatment	\$38.00	\$55.00
➤ Modalities	\$5.00	\$30.00
○ Ultrasound, E-Stim, Myofascial, Traction, Rehab Exercises		
➤ All X-rays and supplies will be the same for cash, personal insurance and unsecured payment arrangements.		
➤ All treatment for Workers Compensation or Personal Injury Claims will be billed out to individual companies as unsecured payment schedule. To see this schedule please ask billing department.		

### **Payment:**

If you have insurance and wish to bill your own insurance, we will supply you with a super bill to do so. (You will pay TOS prices) If you would like Prater View Chiropractic to bill your insurance, we will be happy to do so and you will pay insurance prices. We ask that you pay your co-pay, co-insurance and/or deductible at time of service. If payment is denied by your insurance company you will be responsible for the amount not covered and a statement will be mailed to you. Your account may be assessed interest and/or late fees after 30 days. I/We further agree to pay a finance charge of 18% annual interest rate of the unpaid balances, or a minimum of \$1.50 per month.

**Collections:** All accounts over 90 days past due or not in good standing will be turned over to our collection agency. Monthly payments must be made to keep your account current.

### **Missed Appointments**

We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, **or do not provide us with 24 hours notice**, you will be charged a \$20.00 "broken appointment fee". Broken appointment fees must be paid prior to rescheduling your next appointment.

I have read the above statement and understand this office policy.

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Patient Signature

Date

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Parent or Guardian if patient is a minor

Date

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## **Record Release and Assignment of Insurance Benefits**

The undersigned hereby authorizes the Release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient) \_\_\_\_\_ hereby authorize (Insurance Co.) \_\_\_\_\_  
\_\_\_\_\_ to pay and hereby assign directly to Dr. Darnell Simpson and/or Dr. Devin Simpson all owed benefits. I understand I am financially responsible for all charges incurred.

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Patient Signature

Date

# INFORMED CONSENT FORM

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

## The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

## Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

<input type="checkbox"/> spinal manipulative therapy	<input type="checkbox"/> palpation	<input type="checkbox"/> vital signs
<input type="checkbox"/> range of motion testing	<input type="checkbox"/> orthopedic testing	<input type="checkbox"/> basic neurological
<input type="checkbox"/> muscle strength testing	<input type="checkbox"/> postural analysis	<input type="checkbox"/> testing
<input type="checkbox"/> ultrasound	<input type="checkbox"/> hot/cold therapy	<input type="checkbox"/> Electrical Stim
<input type="checkbox"/> radiographic studies	<input type="checkbox"/> mechanical traction	<input type="checkbox"/> Massage/Myofascial Therapy
<input type="checkbox"/> Physicals (DOT, Sports, other)	<input type="checkbox"/> Other (please explain)	

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## The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

## The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and possible X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

## The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**CONSENT TO TREATMENT (MINOR)**

I hereby request and authorize Dr. Devin Simpson and Dr. Darnell Simpson to perform diagnostic test and render chiropractic adjustment and other treatments to my minor son/daughter: \_\_\_\_\_.

As of this date, I have the legal right to select and authorize health care services for the minor child named above, (if applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.  
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Devin Simpson or Dr. Darnell Simpson* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Doctor's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian  
(if a minor)