Please provide the following information if you are a **NEW PATIENT** to **BRUCE Chiropractic Inc.** .

Full name (last, first, MI) ____

Address ____City_________________ST_______Zip_________

Date of birth ____/____/____Email____

Employment _______________________________ ☐ Retired ☐ Student- full time ☐ Student- part time

☐Single ☐Married ☐ Divorced ☐ Widowed How did you hear about us?_______________________________________

Home phone#_____________________________ Mobile phone#_________________________________

How would you prefer to receive appointment reminders? Please check beside ONLY ONE. ____email ____text

Emergency contact ____ phone#__________________________

Guardian (if patient is a minor) __________________________________ phone# ________________________

POLICIES AND PROCEDURES for Bruce Chiropractic INC.

Payment Policies:

Dr. Bruce is participating (in-network provider) with traditional Medicare. All other insurance companies including Medicare Advantage policies will be processed out-of-network. If you have questions about your coverage, please contact your insurance company with any questions before your appointment.

1. **Proof of Medicare.** All patients must have a picture ID and a Medicare card on file. In addition, your supplement card must also be kept on file for proper claim filing.
2. **Non-covered services.** Medicare patients are responsible for all examinations and therapies as these are not covered by Medicare and are normally denied by secondary's due to Medicare's denial. At your request, we will file your claim for final determination. Payment for denied services is the responsibility of the patient and is due at the time of service. A Medicare ABN form must be on file for us to file these non-covered services.
3. **Check Policy.** All checks must be made payable to Bruce Chiropractic Inc. A service charge of $30.00 will be assessed for each returned check. If we have received more than one returned check from your bank, we will no longer accept payment by check. You will be required to pay by credit card or cash.
4. **Claims submission.** We will submit Medicare claims on your behalf for payment. Medicare may require that you supply certain information directly. It is your responsibility to supply this information directly to Medicare (if requested) for payment processing of the submitted claim.
5. **Medical record request**s are priced individually. Please contact our office to determine your cost.

Appointment Procedures and Policies:

1. **Check-in.** In order to provide all our patients with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive at least 15 minutes early for your appointment. Late arrivals will be worked into the schedule, if the schedule allows.

_____ **2. Cancellations.** Keeping your regularly scheduled appointment is important – for your health, for the
(please initial)
convenience of other patients, and for more efficient operations at our office. If you must cancel or reschedule your appointment, please let us know 24 hours before your scheduled time. A non-cancellation fee of $25.00 will apply to all

appointments not cancelled within this 24-hour time frame. If you fail to show for your scheduled appointment a "no-show" fee of $25.00 will apply.

3. **Phone Calls.** Due to the high volume of calls, you may reach our voice message system. We assure you that these messages are checked regularly, and calls are returned promptly and appropriately during business hours. Our business hours are Monday-Thursday 9-1 and 2-6. To ensure that your needs are met expeditiously, please leave a complete message including your name, your reason for calling, and a contact number so we can return your call.

Notice of Privacy Practices:

Bruce Chiropractic's Notice of Privacy Practices describes how your medical information may be used or disclosed. Please review the document carefully. You may view this Notice on our website or in the office. You may also obtain a paper copy of this notice upon request. I have reviewed a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to: conduct, plan, and direct my treatment and follow up among the healthcare providers who may be directly and indirectly involved in providing my treatment; obtain payment from third party payers, conduct normal healthcare operations such as quality assessments and accreditation.

With your signature below, you affirm that you have fully read and understand the office policies and privacy practices listed above.

Patient/guardian signature____Date______/______/______

PATIENT HEALTH HISTORY

Last Name________________________First_________________________M.I._______ Date of Birth _____/_____/_____

Choose one option: ☐ NEW CONDITION ☐ OLD CONDITION ☐ MAINTENANCE CARE

What can we help you with? ☐NECK Pain ☐HEADACHE ☐PAIN in upper extremity ☐UPPER Back Pain

☐MID BACK Pain ☐SHOULDER Pain ☐RIB Pain ☐LOW BACK Pain ☐HIP PAIN

☐PAIN in lower extremity ☐OTHER____

Where is the condition/pain located (be specific)? ____

Describe how it feels: ☐ DULL ACHE ☐ CONSTANT ☐ SHARP STABBING ☐ NUMBNESS

On a scale from 0-10, rate your condition/pain (circle rating): 0 1 2 3 4 5 6 7 8 9 10

Once it starts, how long does the condition/pain last? ☐ A few MINUTES ☐ A few HOURS ☐ ALL DAY

Is this condition/pain ☐CONSTANT or does it ☐COME and GO?

Explain when and how your condition/pain started? ____

What makes it better? ________________________What makes it worse? _____________________________

Are there any other symptoms associated with this condition/pain (E.g.- numbness, radiates to other area, or pain in extremities)?____

Have you received any treatment for this condition/pain? ____

Health History- Please indicate dates, dosages, and treating physician's name and location for the following:

Prior illness or major injuries: ____

Prior surgeries or hospitalizations: ____

Current Medications ____

List any known allergies: ____

List any relevant family history as it relates to your condition/pain: ____

Social history: ☐ married ☐divorced ☐ widowed

Current employment: _______________________________ Military history: ____________________________________

Please list any use of drugs, alcohol, and/or tobacco. Describe type, length of use, and amount used:

_____________________________ _____________________________ _______________________________

_____________________________ _____________________________ _______________________________

Patient Name: ______________________________ Signature: _____________________________ Date: ___________

Parent or Guardian: ___________________________ Signature: _____________________________ Date: ___________

INFORMED CONSENT TO CHIROPRACTIC CARE- Bruce Chiropractic Inc.

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ________________________Signature: _______________________________ Date: ___________

Parent or Guardian: ____________________Signature: _______________________________ Date: ___________

Witness Name: ________________________Signature: _______________________________ Date: ___________

255 Gilmer Ferry Rd.; Ball Ground, GA 30107   770-737-5200   NPI 1995942288