**WELCOME TO OUR OFFICE….**

The doctors of DiSalvatore Chiropractic are committed to serving those people who desire conservative chiropractic treatment for their health care needs. This commitment begins with collecting enough information from the patient about their condition to arrive at a logical diagnosis. Without a logical diagnosis, treatment options are less effective. This wastes both time and money.

The following forms will provide us with much of the information that will help us help you. Some forms are long and many questions at first may seem irrelevant; however, each question may lead us closer to pinpointing your exact problem and/or aggravation of your complaint.

So please take the extra time to complete all forms to the best of your ability.

**YOUR HEALTH DEPENDS ON IT.**

Dr. Tom DiSalvatore and Staff

**CONFIDENTIAL PATIENT INFORMATION**

**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please circle your preferred method of contact:**

**Patients Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:** S M D W

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_\_\_\_\_**

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person to contact in case of emergency (Name and Phone):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been under Chiropractic Care? \_\_\_\_ Yes \_\_\_ No If so, Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE:**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Name (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your condition due to an auto accident or job related injury? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_No**

## OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Thomas D. DiSalvatore, D.C. Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Thomas D. DiSalvatore, D.C. Inc. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I authorize the office of Thomas D. DiSalvatore, D.C. Inc. to release any medical information necessary to process my insurance claims. I further authorize payment by my insurance company to Thomas D. DiSalvatore, D.C. Inc. for services rendered by the doctors of Thomas D. DiSalvatore, D.C. Inc. if I have not paid for the services. Any overpayment by the insurance company will be returned to the patient or the insurance company. This authorization will continue in effect until I give written authorization not to release such information. I authorize payment of medical benefits to Thomas D. DiSalvatore, D.C., Inc. for services provided.

I will be paying today by: \_\_\_\_\_ Cash \_\_\_\_\_\_\_\_\_ Check \_\_\_\_\_\_\_\_\_\_ Credit Card

\_\_\_\_\_MasterCard \_\_\_\_\_ Visa \_\_\_\_\_ Discover Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_

All accounts not paid within 60 days will automatically be put through on your credit card.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIAL HEALTH HISTORY

FAMILY HEALTH HISTORY

Check any of the following diseases that you, your mother, father, sister, brother, son or daughter have had;

Please specify what type if applicable and who has had the diseases below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clotting Disorder

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psychological Disorder

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Septicemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke/Brain Attack \_\_\_\_\_\_\_\_\_\_\_ Gastrointestinal Disorder

YOUR PERSONALHEALTH HISTORY

Please specify if any of these diseases apply to just yourself:

\_\_\_\_ Measles \_\_\_\_ Polio \_\_\_\_ Tuberculosis \_\_\_\_ Epilepsy \_\_\_\_ Anemia \_\_\_\_ Mumps \_\_\_\_ Small Pox \_\_\_\_Eczema

\_\_\_\_ Chicken Pox \_\_\_\_ Arthritis \_\_\_\_ Whooping Cough\_\_\_\_ Rheumatic Fever \_\_\_\_ Thyroid \_\_\_\_ HIV Positive

Exercise Work Activity Habits

\_\_\_\_\_ None \_\_\_\_\_ Sitting \_\_\_\_\_ Smoking Packs/Day \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Moderate \_\_\_\_\_ Standing \_\_\_\_\_ Alcohol Drinks/Week \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Daily \_\_\_\_\_ Light Labor \_\_\_\_\_ Coffee/Caffeine Cups/Day \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Heavy \_\_\_\_\_ Heavy Labor \_\_\_\_\_ High Stress Level Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS**:

Musculoskeletal Gastro-intestinal CVR Cont’d

\_\_\_\_\_ Low Back Pain \_\_\_\_\_ Poor/Excessive Appetite \_\_\_\_\_ Heart Problems

\_\_\_\_\_ Pain Between Shoulders \_\_\_\_\_ Excessive Thirst \_\_\_\_\_ Lung Problems/Congestion

\_\_\_\_\_ Neck pain \_\_\_\_\_ Frequent Nausea \_\_\_\_\_ Varicose Veins

\_\_\_\_\_ Arm pain \_\_\_\_\_ Vomiting \_\_\_\_\_ Ankle Swelling

\_\_\_\_\_ Joint Pain/Stiffness \_\_\_\_\_ Diarrhea

\_\_\_\_\_ Walking Problems \_\_\_\_\_ Constipation

\_\_\_\_\_ Difficulty Chewing/Clicking Jaw \_\_\_\_\_ Hemorrhoids EENT

\_\_\_\_\_ General Stiffness \_\_\_\_\_ Liver Problems \_\_\_\_\_ Vision Problems

\_\_\_\_\_ Gall Bladder Problems \_\_\_\_\_ Dental Problems

Nervous System \_\_\_\_\_ Weight Trouble \_\_\_\_\_ Sore Throat

\_\_\_\_\_ Nervous \_\_\_\_\_ Abdominal Cramps \_\_\_\_\_ Ear Aches

\_\_\_\_\_ Numbness \_\_\_\_\_ Gas/Bloating after meals \_\_\_\_\_ Hearing difficulty

\_\_\_\_\_ Paralysis \_\_\_\_\_ Heartburn \_\_\_\_\_ Stuffed Nose

\_\_\_\_\_ Dizziness \_\_\_\_\_ Black/ Bloody Stool

\_\_\_\_\_ Forgetfulness \_\_\_\_\_ Colitis Male/Female

\_\_\_\_\_ Confusion/Depression \_\_\_\_\_ Menstrual Irregularity

\_\_\_\_\_ Fainting Genito-Urinary \_\_\_\_\_ Menstrual Cramps

\_\_\_\_\_ Convulsions \_\_\_\_\_ Bladder Trouble \_\_\_\_\_ Vaginal Pain/Infection

\_\_\_\_\_ Cold/Tingling Extremities \_\_\_\_\_ Painful/Excessive Urination \_\_\_\_\_ Breast Pain/ Lumps

\_\_\_\_\_ Stress \_\_\_\_\_ Discolored Urine \_\_\_\_\_ Prostate General

\_\_\_\_\_ Fatigue CVR Females Only

\_\_\_\_\_ Allergies \_\_\_\_\_ Chest Pain

\_\_\_\_\_ Loss of Sleep \_\_\_\_\_ Short Breath When was your last period?\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Fever \_\_\_\_\_ Blood pressure problems Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_ Headaches \_\_\_\_\_ Irregular heartbeat

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIAL HEALTH HISTORY

YOUR PERSONAL HEALTH HISTORY

**Do you have a pacemaker? Y / N When was it implanted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had a knee, hip or shoulder replacement? (Please circle) Y / N**

**Which knee? (Please circle) right left**

**Which hip? (Please circle) right left**

**Which shoulder? (Please circle) right left**

**What medications or drugs are you taking?**

Medications/Doses::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**See medication list provided: (check here)\_\_\_\_\_\_**

**What nutritional supplements are you taking?**

Supplements/Doses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries/Operations and Dates:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Serious Illness, Accidents and Infectious Diseases and Dates:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

**Insurance Coverage**

Welcome to **DiSalvatore Chiropractic.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer’s final payment and benefit determinations.

**Payments**

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

**Private Pay: (please initial)**

**A** As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

**B** I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

**Health Insurance: (please initial)**

**C** I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

**Missed Appointments**

It is the policy of **DiSalvatore Chiropractic** to assess a **$25.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Purposes of Treatment, Payment and Healthcare Operations (HIPAA)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Name of Individual] consent to DiSalvatore Chiropractic’s (“the Practice’s”) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of**

**Notice of Privacy Practices**

***This form will be retained in your medical record.***

**NOTICE TO PATIENT**

**­­­­­­­**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:** **Date of Birth:**

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of DiSalvatore Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by DiSalvatore Chiropractic and informs me of my rights with respect to my protected health information.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Patient’s Signature or that of Legal Representative* |  | *Printed Name of Patient or that of Legal Representative* |
|  |  |  |
| *Today’s Date* |  | *If Legal Representative, Indicate Relationship* |
|  |  |  |

**Informed Consent for Treatment Document**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**The nature of the chiropractic adjustment.**

The primary treatment used by doctors 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:

Spinal/extremity/cranial manipulative therapy Range of motion testing

Palpation Muscle strength testing

Vital signs Postural analysis testing

Orthopedic testing Basic neurological testing

Ultrasound EMS

Hot/cold therapy Radiographic (x-ray) studies

Nutritional counseling Biometric mensuration

Other (Please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone

which we check for during the taking of your history and during examination and 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.

**Informed Consent for Treatment Document (continued)**

**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 choose 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.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

**I have read ( ) or have read to me ( ) the informed consent document explaining the chiropractic adjustment and related treatment. I have discussed it with the doctors at DiSalvatore Chiropractic 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)**