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_____

Would you like to receive a monthly email newsletter from our office? Please initial here _____ for yes.

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

☐Married ☐ Divorced ☐ Widowed How did you hear about us?_____

Home phone#_____ Mobile phone#_____

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

Emergency contact _____ phone#_____

Guardian (if patient is a minor) _____ phone# _____

POLICIES AND PROCEDURES for Bruce Chiropractic INC.

Payment Policies:

Dr. Bruce participates with most insurance plans. If you are NOT insured by a plan in which we participate, payment in full is expected at the time of your visit. Understanding your insurance benefits is your responsibility. Therefore, please be sure that you verify that Dr. Bruce is in your network, what your out-of-network benefits are, and what your insurance covers. If you have questions about your coverage, please contact your insurance company with any questions before your appointment.

1. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. If payment is not made at the time of service, there will be an additional charge of $20.00 for an administrative fee.
2. **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.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may not be covered by your insurance plan. If you receive such services, you will be required to pay for these services in full at the time of visit. 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. With your request, we will file your claim for final approval or denial of services. Payment for denied services is the responsibility of the patient.
4. **Proof of insurance.** All patients must have a picture ID and an insurance card on file. If you cannot provide proof of insurance, you may be responsible for the claim.
5. **Claims submission.** We will submit claims on your behalf to your insurance company for payment. Your insurance company may require that you supply certain information directly. It is your responsibility to coordinate your benefits with your carrier. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit, so we can update your insurance information in our system. Providing us with this information prior to your visit will reduce your wait time. We will also do our best to verify your insurance coverage prior to your visit to minimize surprises at the time of visit.
7. **Medical record requests** are priced individually. Please contact our office to determine your cost.

Appointment 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 yourscheduled appointments and arrive at least 15 minutes early for your appointment. Late arrivals will be worked into the schedule, if schedule allows.
2. **Cancellations.** Keeping your regularly scheduled appointment is important – for your health, for the 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. These charges are not billable to your insurance provider and are your responsibility.
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. Please note that any medical questions must be forwarded to the provider for review. Since our provider may be busy with patients during the day, it may take some time to reply to your question.

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

Patient/guardian signature_____Date_____/_____/_____

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 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.

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 ☐ NUMB

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 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: _____