Cornerstone Chiropractic

"The power that made the body heals the body."

_____
Today's Date

Tell Us About Yourself

Patient Name: _____ SS #: _____-_____-_____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____-_____-_____

Birth Date: ____/_____/_____ Height: ___ft ___in Weight: _____lbs ❒ Male ❒ Female

Cell Phone: ____-_____-_____ Email: _____

Please indicate the best way to contact you: _____

Who were you Referred by: _____

Chief Complaint: _____

Previous Chiropractor: _____ Date of last visit: ____/_____/_____

Reason for last visit: _____

Name of M.D./ D.O.: _____ Date of last visit: ____/_____/_____

Reason for last visit: _____

Tell us about the Insured Person

I am the insured person: ☐

Insured's name:_____

Address:_____

Phone: _____

SSN: _____ Birthday: _____

What is your relationship to the insured person: _____

Primary Insurance Company:

Name:_____

Contact/Identification #:_____Co-Payments amount:$_____

Group #_____ Effective Date:_____

Employer Name:_____ Employer Address:_____

Secondary Insurance Company:

Name:_____

Contact/Identification #:_____Co-Payments amount:$_____

Group #_____ Effective Date:_____

Employer Name:_____ Employer Address:_____

Patient Health Information Consent Form

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Be assured that this office will limit the release of all PHI to the minimum needed.
2. The patient has the right to examine and obtain a copy of their own health records at anytime and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. Patients have the right to file a formal complaint with our privacy office about any possible violations of these policies and procedures.
6. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

*Signature:_____ Date: _____

Financial Responsibility

I understand that I am financially responsible to pay deductibles, co-insurance or any other balance not paid by my insurance.

*Signature:_____ Date: _____

Medicare patients

I request that payment of authorized Medicare benefits be made on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to Cornerstone Chiropractic and its agents any information needed to determine these benefits or the benefits payable for related services.

The office will accept assignment of your Medicare health claim. Each year you must meet a deductible. Co-pays will be due at the time of service. Medicare will only pay for services that it determines to be reasonable and necessary. If Medicare determines at a particular service is not reasonable and necessary under their guidelines, they are likely to deny payment for chiropractic manipulative therapy.

If Medicare denies payment, I agree to be fully and personally responsible for payment.

*Signature:_____ Date: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic: The doctor will use his hands or a mechanical device in order to adjust your joints. You may feel a "click" or a "pop," such as the noise you would hear when you crack your knuckles. Various ancillary procedures, such as hot and cold packs, or traction may also be used during your treatment.

Possible risks: As with any health care procedure, complications are possible following chiropractic manipulation or adjustment. Complications could include fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to interverterbral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries in the neck. Patients may experience stiffness or soreness after the first few days of treatment. The ancillary modalities could produce skin irritation, burn or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin, one in ten million, and can be further reduced by screening procedures during your initial examination. The probability of adverse reactions due to ancillary procedures is also considered rare.

Risks of Remainging Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition, and make further rehabilitation more difficult. Failure to follow your Doctor's recommended treatment plan may decrease your ability to get well, and may aggravate your present condition.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

*Signature:_____ Date: _____