

Natural Way Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Legal name (first and last) _____

Nickname or name you preferred to be called _____

DOB _____ Age _____ SSN _____

Gender _____ Preferred pronouns (optional) _____ Marital Status _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address _____

Employer _____ Occupation _____

Partner (if applicable) _____ Partner's Employer _____

Emergency Contact _____ Relationship _____ Phone _____

Do you have insurance? (mark one) _____ No _____ Yes; If yes, please provide front desk with copy of insurance card(s)

Who referred you to, or how did you hear about, our office? _____

Is your visit due to a car accident or work injury? (mark one) _____ No _____ Yes; If yes, please see front desk for an injury report

Your present complaints/symptoms _____

List other doctor(s) seen for this condition _____

Personal Medical history (if any of the following are relevant to your medical history, please check all that apply)

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | |

Have you ever had chiropractic care? (circle) Yes No Date of last adjustment _____

Have you ever had massage therapy? (circle) Yes No Date of last massage _____

Describe any operations you've had and the dates: _____

Have you been treated by a physician for any health conditions in the last year? Yes No

Describe condition _____ Date of last physical exam _____

Are you now taking any medication? (circle) Yes No What Kind? _____

What supplements/vitamins are you currently taking? _____

Are you pregnant? (circle) Yes No Date of last menstrual period _____

I hereby authorize payment directly to this medical office for Medicare and/or group insurance benefit otherwise payable to me. I authorize release to the Centers for Medicare services and/or group insurances any medical information needed to determine the payments for related services. I understand that I am responsible for all costs of medical treatment. I certify that all of the above information is correct.

Patient/Legal Guardian Signature

Date

Printed name if signed on behalf of patient

Relationship



OFFICE POLICIES

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues, regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage

Complimentary Consultation: Natural Way Chiropractic will conduct a special no charge consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy: We feel the patient’s health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services: Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office, and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker’s Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and letters of protection are signed.

Health Insurance: Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Natural Way Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Natural Way Chiropractic will be credited to your account upon receipt.

Appointments: Our office sends email and text appointment reminders (if subscribed), however, they are a courtesy only and not to be relied on. Please call our office as soon as possible if you are not going to make your scheduled appointment. To better serve our patients, we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. For massage therapy services, our office has no show/late cancellation fees if we fail to receive 24 hours notice prior to your appointment as well as late arrival/early departure fees. Fees are dependent on the service and length of time you were scheduled.

Identification Policy: Natural Way Chiropractic requires a copy of photo identification (ex: driver’s license, passport, student ID) to be on file to receive care. Also, we require an electronic photo to be taken and placed in your medical chart for verification purposes.

Questions and Answers: Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Natural Way Chiropractic clinic policies and agree to honor them:

Patient/Legal Guardian Signature

Date

Printed name if signed on behalf of patient

Relationship



ASSUMPTION OF FINANCIAL RESPONSIBILITY

I, the undersigned patient, completely understand that Natural Way Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Natural Way Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Natural Way Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Natural Way Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file" to bill my insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic.

I understand that Natural Way Chiropractic, PS may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I agree to pay any co-pay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Patient/Legal Guardian Signature **Date**

Printed name if signed on behalf of patient **Relationship**

INFORMED CONSENT

Chiropractic examination and therapeutic procedures (including spinal adjustment, cold application, and manual muscle therapy) are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs and spinal fractures.

Therapeutic procedures (including massage therapy, cold application, and heat application) are considered safe and effective methods of care. Draping will always be utilized, and only the body part being worked on will be exposed if necessary. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. I understand it is my responsibility to let my massage therapist know of any pain or discomfort I am having during the session, or if I'd like the pressure to be less or more at any time. I have also notified my massage therapist of all known medical conditions and injuries. I also understand this is a doctor's office and that my massage is entirely therapeutic and non-sexual in nature.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. By signing this release, I hereby waive and release my provider for any and all liability, past, present and future relating to chiropractic, massage therapy, and bodywork.

Patient/Legal Guardian Signature **Date**

Printed name if signed on behalf of patient **Relationship**



PRIVACY PRACTICES AND RELEASES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Natural Way Chiropractic. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

****By signing below, I acknowledge receipt of the Notice of Privacy Practices****

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to those indicated below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Our doctors take your healthcare seriously and find it extremely important to keep your primary care provider up to date on your care. Please provide us with the name and location of your PCP and we will send them your current exam findings and any other requested information.

Primary Care Provider/Location: _____

Patient/Legal Guardian Signature

Date

Printed name if signed on behalf of patient

Relationship

CONSENT TO USE ELECTRONIC SCRIBE

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

The electronic scribe assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. The tool does not interact with you directly; it merely listens to the conversation and creates a summary. This note is then reviewed and approved by your practitioner.

We want to assure you that your privacy is our utmost priority. The scribe tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. **Our electronic scribe does not utilize any patient names or demographics and is used only as a dictation tool.** Only the healthcare professionals involved in your care will have access to these notes.

I consent to the use of Electronic Scribe during my medical encounters/appointments.

Patient/Legal Guardian Signature

Date

Printed name if signed on behalf of patient

Relationship

OFFICE USE ONLY

Pt. ID: _____ DOB: _____

99204 99214

Merge SOAP notes selected

PCP Referral? Yes

DUD/Rivermead Yes No



PERSONAL INJURY HISTORY FORM

1. Name: _____ Today's Date: (____ / ____ / ____)
2. Date of Accident: (____ / ____ / ____). What time was the accident? _____ (am/pm)
3. Were you working/on the clock when this accident occurred? Yes No
4. Weather Conditions? sunny clear drizzling rainy foggy snowy cloudy partly cloudy stormy
5. How were the road conditions? dry damp wet snowed over iced over dry with ice patches
6. Do you have a lawyer for this claim? No Yes, If yes, who? _____
7. Vehicle you were in: Year _____ Make _____ Model _____
8. Type of your vehicle: sports car coupe sedan SUV station wagon pickup truck bus
 Other _____
9. Vehicle size: compact mid-size full-size
9. Place you were seated in the vehicle: driver front passenger back passenger driver side
 back passenger right side back passenger middle
10. If you were the driver, was your foot on the brake? Yes No N/A
11. Actions of patient's vehicle: crossing intersection stopped at an intersection stopped for traffic
 stopped for pedestrian traveling at posted speed limit traveling faster than the posted speed limit turning
12. How was the patient's vehicle hit? was rear ended hit head on was hit on the left front was hit on the right front
 was hit on the left rear was hit on the right rear Other _____
13. Did you have a safety belt on? Yes No Shoulder strap? Yes No
14. Is your car equipped with Airbags? No Yes, If yes, did airbags deploy? Yes No
15. What direction were you going? (N, E, S, W) other: _____
16. What street was the accident on? _____ Nearest cross street? _____
17. How fast were **you** going at time of accident? _____ MPH
18. Did any part of your body strike any part of the vehicle? No Yes, If Yes, please explain:

19. Does your vehicle have a headrest? Yes No
20. What part of your body is the top of your headrest located? Neck Middle of your head
 Even with the top of your head Above top of your head Other _____
21. How aware were you at time of impact? not aware partial very Other _____
22. Please explain in detail how the accident happened. _____

DESCRIBE THE MOMENT OF IMPACT

23. What position was your **body** at time of impact? straight leaning forward slouched down in seat
 turned to the left turned to the right bent left bent right Other _____
24. What direction was your **body** thrown at time of impact? backward then forward forward then backward
 to the left to the right outside the vehicle under the vehicle Other

25. What position was your **head** at time of impact? straight tilted forward bent left bent right,
 twisted/rotated to left twisted/rotated to the right tilted up Other _____
26. What direction was your **head** thrown at time of impact? backward then forward forward then backward
 side to side Other _____
27. Did you feel or hear a popping, tearing, or a ripping noise in your neck or back? No Yes, If Yes, please
 explain: _____

28. Did your vehicle strike another vehicle? (was a 3rd vehicle involved): No Yes, If Yes, please explain:

29. Was the vehicle you were in totaled? Yes No Most likely Unknown
30. What is the estimated cost of damage of the vehicle you were in? \$ _____ Unknown

31. What is the **second** vehicle: Year _____ Make _____ Model _____

32. **Describe** the **second** vehicle: compact full-size mid-size bus pick-up truck semi-trailer

33. What direction was the **second** vehicle going at time of impact? (N, E, S, W) Other: _____

34. How fast was the **second** vehicle going at time of impact? _____ MPH

35. **Describe 3rd** vehicle (If applicable): compact full-size mid size bus pick-up truck semi trailer

36. **3rd vehicle** information (if applicable): Year _____ Make _____ Model _____

AFTER THE ACCIDENT:

37. Did the police come to the accident? Yes No Was a police report filed? Yes No N/A

38. Were traffic tickets issued? No Yes, If Yes, to whom: you the other driver the driver of your vehicle

39. Did you lose consciousness after impact? No Yes, If Yes, please explain: _____

40. After the accident were you: stunned shook up shocked other: _____

If so, for how long? _____

41. Did you feel any pain? No Yes, If Yes, where? _____

42. How soon after the accident did you feel pain? _____

43. Is your pain worse in the: AM PM Constant Same Throughout

44. Did you, or have you had any numbness, tingling or pain going down your arms, hands, legs or feet since the accident? No Yes, If Yes, explain: _____

45. Did you notice any bruising? No Yes, If Yes, where? _____

46. Did you take an ambulance to the hospital after the accident? No Yes, If Yes, what hospital?

47. If you did go to the hospital what procedures were done? Exam X-Rays MRI CT
 Chiropractic Referral Physical Therapy Referral Massage Therapy Referral
Other? _____

48. Were you examined by another healthcare professional after the accident? No Yes

If Yes, by whom? _____ When/Date? _____

49. What was done? Chiropractic Referral Physical Therapy Referral Massage Therapy Referral
 Other? _____

50. Were you prescribed any medication? No Yes, If Yes, what kind(s)? _____

51. Was a diagnosis given? No Yes, If Yes, what did they diagnose you with? _____

52. What have you tried to make your symptoms better? ice heat stretch exercise massage
 Other: _____

53. What do you do that make your symptoms worse? _____

54. Have you missed work as a result of this accident? No Yes, If Yes, how many days? _____

55. What is your occupation? _____

56. What duties are required of you on the job? _____

57. Have you ever seen a chiropractor? No Yes, If Yes, when and who?

58. Have you ever had spinal X-rays? No Yes, If Yes, when and where?

59. What are your current symptoms? Headaches Migraines Neck Pain Upper back pain
- Shoulder pain (Left Right Both) Mid back pain Low back pain Hip Pain (Left Right Both)
- Knee pain (Left Right Both) Arm/hand pain and tingling (Left Right Both)
- Leg/foot pain and tingling (Left Right Both)

60. Compared with **before** the accident, do you **now** suffer from: Mood changes Feelings of dizziness
- Nausea and/or vomiting Noise sensitivity Sleep disturbance Fatigue Forgetfulness Poor Memory
- Poor concentration Taking longer to think Blurred vision Light sensitivity Restlessness
- Feeling depressed or tearful Feeling frustrated or impatient Being irritable Easily angered
- Ringing in the ears Lack of energy Difficulty sleeping Seeing stars
- Other, please explain: _____
- _____
- _____

BELOW IS FOR OFFICE USE ONLY

Patient is concerned and now seeking the necessary massage therapy and chiropractic care.

SUBJECTIVE COMPLAINTS

P1: _____ O _____ F _____ D _____ I _____ /10

P2: _____ O _____ F _____ D _____ I _____ /10

P3: _____ O _____ F _____ D _____ I _____ /10

P4: _____ O _____ F _____ D _____ I _____ /10

P5: _____ O _____ F _____ D _____ I _____ /10

Enter Dragon Disclaimer