A.O. CHIROPRACTIC
AND BALANCE

PATIENT INFORMATION

Date: ____/____/____ File #: _____

Name: _____ Preferred Name: _____

SS#: _____ DOB: ____/____/____ Age: _____ Male Female

Address: _____ City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email Address: _____

Status: Minor Single Married Other: _____ Spouse's Name: _____

Do you have children? Yes No If yes, how many? _____

Have you seen a chiropractor before? Yes No Clinic/Doctor's Name: _____

Who is your Medical Doctor? _____ Phone: _____

Would you like for us to send a report of findings to him or her? ____Yes ____No

How did you hear about us? ____Website ____Search Engine ____Walk by ____Social Media ____Yellow pages

Doctor:_____ Friend:_____

Emergency Contact

Name: _____ Relation: _____ Phone: _____

Employment Information

Employer Name: _____ Occupation: _____ How long? _____

Address: _____ City, State, Zip: _____

Primary Insurance

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Address: _____

_____

Insured's Name: _____

Insured's Employer: _____

Insured's SS#: _____

Relation: _____ DOB: _____

Secondary Insurance

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Address: _____

_____

Insured's Name: _____

Insured's Employer: _____

Insured's SS#: _____

Relation: _____ DOB: _____

Person ultimately responsible for account (if same as patient, please leave blank)

Name: _____ Relation: _____ DOB: _____

Billing Address: _____

Driver's License #: _____ Phone: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

MEDICAL HISTORY

Reason for today's visit: _____ Emergency _____ New injury _____ Old injury _____ Chronic pain ____ Wellness

Are you in pain? _____ Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Where did your injury occur? _____ Work _____ Sports/Play _____ Auto Accident ____ Routine/Household Activity

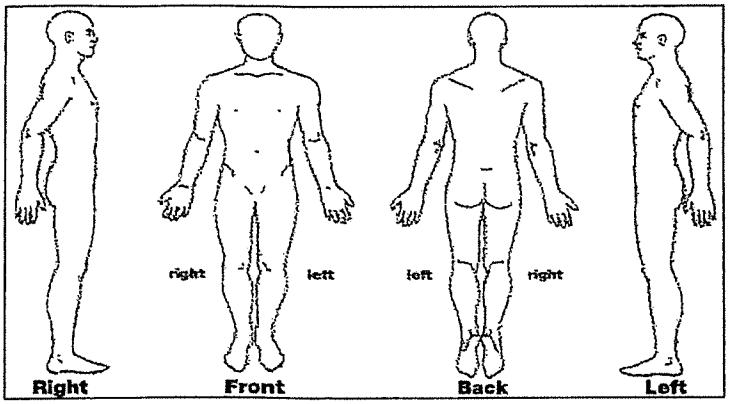
When did your condition/accident occur? _____ Where? _____

Please explain what happened: _____

Is condition interfering with: _____ Work _____ Sleep or _____ Daily routine? If so, how: _____

Has this or something similar happened in the past? Yes No If Yes, explain: _____

Using the body chart below, please circle all affected areas.



Y N Heart Attack/Stroke
Y N Fainting/Seizures/Epilepsy
Y N Psychiatric Problems
Y N Heart Surgery/Pacemaker
Y N Artificial Valves
Y N Severe/Frequent Headaches
Y N Rheumatic Fever
Y N Hepatitis

Are you taking any of the following medications?

Nerve pills Painkiller (i.e. Aspirin) Muscle Relaxers
Blood thinners Tranquilizers Insulin Other: _____

Please circle yes (Y) or no (N) on the following:

Y N Difficulty Breathing
Y N Chemotherapy
Y N Heart Murmur
Y N Shingles
Y N Venereal Disease
Y N HIV/AIDS/ARC
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N Frequent Neck Pain
Y N Anemia/Diabetes
Y N Mitral Valve Prolapse
Y N Cancer
Y N Lower Back Pain
Y N Kidney Problems
Y N High/Low Blood Pressure
Y N Artificial Bones/Joints
Y N Tuberculosis
Y N Emphysema/Asthma
Y N Arthritis
Y N Glaucoma
Y N Ulcers/Colitis
Y N Sinus Problems

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

List any serious accidents with dates: _____

Family health history: _____

Take supplements/vitamins? No Yes Do you exercise? No Yes If yes, how often? _____

Do you smoke? No Yes How often? _____ For how long? _____

Do you drink alcohol? No Yes If so, how many drinks per week? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting? No Yes Since: _____

For women only: Are you on birth control? No Yes Are you nursing? No Yes

Are you pregnant? No Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting on your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____ DATE: _____

CONSENT TO TREATMENT AUTHORIZATION

By my signature below, I certify that the above information is correct. I authorize A.O. Chiropractic Dr. Kristal Schmidt to perform an examination, take x-rays if necessary, and administer chiropractic treatment. I authorize A.O. Chiropractic Dr. Kristal Schmidt to contact other health care providers I have to coordinate my care, and to release information to my other providers for coordination of care, and to release my health information for insurance reimbursement purposes.

_____ _____/_____/_____

Patient Signature Date

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of A.O. Chiropractic Dr. Kristal Schmidt Notice of Privacy Practices for Protected Health Information, and I have been told that a copy is available at the front desk at any time.

_____ _____/_____/_____

Patient Signature Date

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise cure for any symptoms, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.
The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating **vertebral subluxations** (spinal misalignments and resultant nerve interference).
2. Adjustment of the spine for the purpose of correcting **vertebral subluxations**.
3. Education and encouragement of our patients/practice members to become aware of and responsible to their well-being.
4. Empowerment of our patient/practice members as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I understand the practice of chiropractic as outlined, I am aware of the risks as outlined above, and wish to receive care at A.O. Chiropractic Dr. Kristal Schmidt for myself/my family.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Authorized Provider Representative Printed Date

Witnessing signing of: ☐ Authorization to treat ☐ Insurance assignment ☐ Privacy Notice ☐ Pregnancy Disclaimer
☐ Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the bodys correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the Spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 Vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

1.

Please give us a minimum of 4 hours' notice if canceling your appointment. When we are not notified there will be a 65.00 missed appointment fee billed to your account.

2.

When Campbell County School District cancels school AOC will be closed for the day as well. We will call you to reschedule appointments as soon as possible.

Please sign in acknowledgment to this policy:

Signature: _____

Date:_____