IDAHO CHIROPRACTIC GROUP

NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

Today's Date ___/___/20___ **Date of Birth**___/___/_____

Full Name:_____ Email:_____ Gender: F M
Address:_____City:_____State:_____Zip: _____
Cell Phone:_____Work Phone: _____
Employer:_____Occupation: _____
Employer Address:_____City:_____State:_____Zip:_____

Spouse/Parent/Guardian:_____Birth Date:___/___/___
Employer:_____Occupation: _____
Cell Phone:_____ Work Phone:_____

Emergency Contact:_____Relationship: _____
Cell Phone:_____Work Phone: _____

Primary Medical Physician: _____

How did you hear about us? Please circle one: Internet Referral Other:

We want you to know how our Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- **The patient understands and agrees to allow Idaho Chiropractic Group to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.**
- **The patient has the right to examine and obtain copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions for the use of their PHI. Our office is not obligated to agree to those restrictions.**
- **A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.**
- **The patient may provide a written request to revoke consent any time during care. This would not affect 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.**
- **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. We have taken all precautions that are known by Idaho Chiropractic Group to assure that your records are not readily available to those who do not need them.**
- **Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.**
- **If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to provide care.**

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

_____ _____
Print Patient Name **Patient/Parent/Guardian Signature**

If Female: Date of Last Menstrual Period:___/____/ Pregnant? ☐Y ☐N Nursing? ☐Y ☐N

SURGICAL PROCEDURES: _____

_____

_____

_____

TREATMENT: *What type of treatment are you looking for?*

☐ The most minimal amount care to "patch up the symptoms" of my problem.

☐ To resolve my symptoms and then go on to "fix the cause" of my problem.

☐ Take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: *in relation to your primary complaint:*

Is this a new problem? ☐Y ☐N

If this is a recurrence, when was the first time you noticed this problem?

How did it originally occur?_____Has it become worse recently? ☐Y ☐N ☐Same

Has another doctor(s) treated you for this condition? ☐Y ☐N If yes, whom? _____When?

Treatment(s):_____Have you had any intolerance of reactions to treatments? ☐Y ☐N

If yes describe:

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐At Night Only

How long does it last? ☐All day ☐Few hours ☐Minutes

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Twisting ☐Lifting ☐Other:

How long has it been since you've really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐>10 years

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other:

Has there been anything that has relieved your problem? ☐Ice ☐Heat ☐Medication ☐Stretching ☐Other:

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N

*If yes describe:*_____

_____

Have you ever been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

Describe:_____

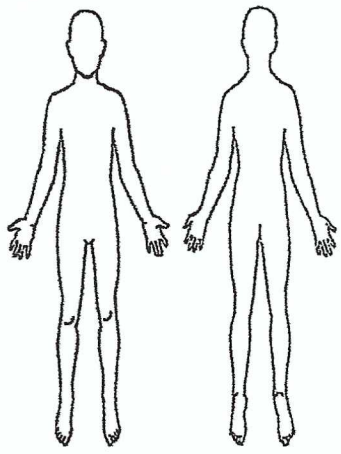
_____

Please check all of the symptoms that apply. (P=Past/ C=Current)

P/C	P/C	P/C
☐ ☐ Headache	☐ ☐ High Blood Pressure	☐ ☐ Tingling in Feet
☐ ☐ Facial Pain	☐ ☐ Low Blood Pressure	☐ ☐ Walking Problems
☐ ☐ Eye Pain	☐ ☐ Abdominal Pains	☐ ☐ Sore Muscles
☐ ☐ Blurred Vision	☐ ☐ Nausea/Vomiting	☐ ☐ Weak Muscles
☐ ☐ Dizziness	☐ ☐ Poor Appetite	☐ ☐ Paralysis
☐ ☐ Earache	☐ ☐ Fullness of Bladder	☐ ☐ Shakiness
☐ ☐ Forgetfulness	☐ ☐ Urination Difficulty	☐ ☐ Sweating
☐ ☐ Confusion	☐ ☐ Frequent Urination	☐ ☐ Insomnia
☐ ☐ Sinusitis	☐ ☐ Constipation	☐ ☐ Fainting
☐ ☐ Teeth Grinding	☐ ☐ Hemorrhoids	☐ ☐ Convulsions
☐ ☐ Dry Mouth	☐ ☐ Decreased Sex Drive	☐ ☐ Irritability
☐ ☐ Excessive Thirst	☐ ☐ Menstrual Irregularities	☐ ☐ Impatience
☐ ☐ Unpleasant Taste	☐ ☐ Elbow/Hand Pain	☐ ☐ Fatigue
☐ ☐ Neck Pain	☐ ☐ Tingling in Hands	☐ ☐ Feel Loss of Control
☐ ☐ Sore Throat	☐ ☐ Clammy Hands	☐ ☐ Other:_____
☐ ☐ Lump in Throat	☐ ☐ Low Back Pain	_____
☐ ☐ Swallowing Pain	☐ ☐ Hip Pain	
☐ ☐ Unsteady Voice	☐ ☐ Knee Pain	
☐ ☐ Shoulder Pain	☐ ☐ Poor Circulation	
☐ ☐ Persistent Coughing	☐ ☐ Swollen Joints	
☐ ☐ Chest Pressure	☐ ☐ Joint Stiffness	
☐ ☐ Slow Heart Rate	☐ ☐ Swollen Ankles	
☐ ☐ Rapid Heart Rate	☐ ☐ Ankle/Foot Pain	

Please use the symbols below to mark the areas in which you feel these sensations.

Stabbing/Cutting-///
Burning-XXX
Numbness-═══
Tingling-:::
Cramping-^^^
Dull-###



HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda/Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

Exercise ☐ 5-7x/wk ☐ 3-5x/wk ☐ 1-3x/wk ☐ None

Sleep ☐ 8+hrs ☐ 7-8hrs ☐ 6-7hrs ☐ 5-6hrs ☐ <5hr

Meals/Day ☐ 5+ ☐ 4 ☐ 3 ☐ 2

Water/Day ☐ 64+oz ☐ 32-64oz ☐ 16-32oz ☐ <8oz

WORK ACTIVITY ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Walking/Moving ☐ Driving

FAMILY HISTORY *Identify any conditions that you, or any of your family members have had in the past: (**G**= Grandparents, **M**=Mother, **F**=Father, **S**=Siblings, **X**=Self)*

___Alcoholism	___Eczema	___Miscarriage	___Tumor(s)
___Anemia	___Emphysema	___Mumps	___Ulcer(s)
___Cancer	___Epilepsy	___Pleurisy	___Other: _____
___Cold Sores	___Goiter	___Pneumonia	_____
___Deep vein Thrombosis	___Gout	___Polio	_____
___Detached Retina	___Heart Disease	___Pheumatic Fever	_____
___Diabetes	___HIV/AIDS	___Stroke	_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION:

_____

_____

_____

_____

HIPPA ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE ACCESS TO A COPY OF Idaho Chiropractic Group, PLLC's privacy notice that has an effective date of June 16, 2004. 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 procedure in our office. We have taken all precautions that are known by Idaho Chiropractic Group to ensure that your records are not readily available to those who do not need them.

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

_____

Print Patient Name Date

_____

Patient or Guardian Signature Date

IDAHO CHIROPRACTIC GROUP

Financial Policy

Thank you for choosing Idaho Chiropractic Group, PLLC as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we require you to read and sign prior to any treatment.

All payments are due at the time of service. We accept Cash, Check, Visa, MasterCard, Discover and American Express. We accept assignment of insurance benefits from your insurance carrier. However, it is the patient's responsibility to ensure that the insurance carrier meets their obligations. The contract is between you and your insurance carrier. We are not a party to that contract. If your insurance has not paid the bill within 45 days, you will be asked to make a payment on the account to stay in good standing. We encourage you to contact your insurance company for any discrepancies. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Ada County, Idaho. You further understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible of those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Unless appointments are canceled at least 24 hours in advance, we reserve the right to charge for missed appointments with a $25.00 cancellation fee. There is a fee (currently $20.00) for any checks returned to us by the bank.

We reserve the right to charge a monthly late fee in the amount of $5.00 for accounts past 60 days. If no payment has been made in the last 60 days from any date of service, the late fee may be applied to your account.

If you are interested in payment arrangements, a consultation can be arranged. Please contact the front desk.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I have read the financial policy. I understand and agree to the terms of this agreement.

☐ **I have provided a copy of my insurance card** ☐ **I am a cash patient (no insurance)**
☐ **This will be billed to personal injury or work comp**

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company named above and assign directly to Idaho Chiropractic Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Idaho Chiropractic Group may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Print Name

IDAHO CHIROPRACTIC GROUP

CONSENT TO TREATMENT

Please read the entire document and ask questions before you sign if there is anything that is unclear.

The nature of chiropractic adjustment.

The primary treatment I use as a Doctor 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 to move your joints. That may cause an audible "pop" or "click," just like what you may experience when "cracking" your knuckles. You may feel a sense of movement.

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, and separations. Some types of manipulation of the neck have been associated with injuries to the arteries leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your conditions 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 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.

I have read or have had read to me the above explanation of chiropractic adjustment and related treatment. I have discussed it with Dr. Klena/Dr. Matthews/Dr. Asla 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.

Date: _____ Date: _____

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

403 S. 11th St. Ste. 110, Boise ID 83702 (208) 343-6900