chiropractic
HEALING ARTS CENTER

Patient Information Sheet

PATIENT

First Name: _____ Last Name: _____ MI: _____

Gender: M / F / GN Date of Birth: _____/_____/_____

Home Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell: (_____) _____-_____ E-mail*: _____

* (optional) email used for electronic statements or for Fullscript (website for direct personal supplement orders).

SPOUSE OR GUARDIAN (if a minor)

First Name: _____ Last Name: _____ MI: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell: (_____) _____-_____ Relationship to Patient: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____ MI: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell: (_____) _____-_____ Relationship to Patient: _____

Referred By (optional): _____

Payment Method: Cash ____ Check ____ Credit Card* ____

*We only accept Visa, Mastercard, and Discover Cards

PATIENT SIGNATURE: _____ Date: _____

PARENT/GUARDIAN (if a minor):

Name: _____ Signature: _____ Date: _____

Consent for use and/or disclosure of protected health information to carry out treatment, payment, and/or other health care options

To our patients: Before you begin treatment at Chiropractic Healing Arts Center, LLC (hereafter called "the Office") the law requires that we explain your rights and responsibilities while a patient at the Office. If you have a complaint or concern about your case, please discuss it first with your care provider. If your concern remains unresolved, you may call the Privacy Officer, Gemma Miller, at (952)-831-1441.

Consent for treatment: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that examination could include physical examinations, lab tests, diagnostic imaging, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

Release of medical records for my medical care or as required by law: I understand it is important that my medical providers have access to any of my medical records which may help them to safely treat me and manage my medical care. I agree that a copy of my medical records may be sent to any of my physicians or healthcare providers. This includes release to any hospital in which the Office may be contacted for the purposes of medical care and for the business operations relating to my health. I also agree that the Office can release my records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records.

Release of medical records for billing purposes and personal injury cases: For a "third party payer" to pay any or all of my bills related to my visits at the Office, I understand the "third party payer" may require information about the medical care and treatment I received. I authorize the Office to release to the "third party payer" any information needed to determine the payments related to the medical treatment I received.

Patient's right to privacy: I acknowledge that I have been made aware of the Office's privacy practices. If I would like a copy of the Office's privacy brochure, I may ask for one. I understand that I have the right to revoke this consent, in writing, at any time except where the Office has already made disclosures in reliance of this consent.

Patient

Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian (if a minor)

Name: _____ **Signature:** _____ **Date:** _____

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Financial Policy

Payment

Payments are due at the date of service. Cash, check, and credit cards (Visa, Mastercard, Discover) are acceptable forms of payment. If you wish to submit a claim to your insurance company, please inform the person at the front desk and they will provide a statement for you with all the pertinent information.

Missed and Late Appointments

A **24-hour notice** is required to reschedule or cancel an appointment. If a 24-hour notice is not given, a $75.00 late cancellation fee will be charged and must be paid before or during the next appointment.

Please call if you anticipate being late for an appointment. If you are late, you may be able to be seen by the doctor. However, you will be seen for the remaining time of your appointment.

I have read, understand, and agree to the Financial Policy.

Patient

Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian (if a minor)

Name: _____ **Signature:** _____ **Date:** _____

Informed Consent for Acupuncture Care

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

It is important that each patient understands both the objective and the methods of acupuncture care. The objective of acupuncture care is to facilitate the balance of energy, Qi, in the body and promote blood flow to aid in healing. Acupuncturists may insert fine needles into acupuncture points on the body to increase, decrease, or redirect the flow of Qi as needed. Acupuncture care may also use low voltage electrical instruments in conjunction with needles.

Risks associated with acupuncture care may include mild bruising and temporary soreness at the site of treatment.

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

Acupuncture care does not offer to diagnose or treat any disease or condition. If we encounter unusual findings during our examination, we will advise you accordingly.

All questions regarding the acupuncturist's objective pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept acupuncture care on this basis.

Patient

Name: _____ **Signature:** _____ **Date:** _____

Consent to evaluate and treat a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive acupuncture care.

Parent/Guardian

Name: _____ **Signature:** _____ **Date:** _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce subluxations. Our chiropractic method or correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as therapeutic services and/or acupuncture may be included.

If we encounter non-chiropractic or unusual findings during the course of care, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Patient

Name: _____ **Signature:** _____ **Date:** _____

Consent to evaluate and treat a minor child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian

Name: _____ **Signature:** _____ **Date:** _____

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Patient History

Name: _____ **Date:** _____

Occupation: _____

Hospitalizations: _____

Surgeries: _____

Illnesses: _____

Family History (Self, Biological Parents/Siblings/Grandparents)

High Blood Pressure: _____ Lung Conditions: _____

Diabetes: _____ Arthritis: _____

Heart Disease: _____ Allergies: _____

Cancer: _____ Other: _____

Exercise: Y or N , If yes, what activities and how often: _____

_____

Typical Diet: _____

Caffeine Y or N , How much: _____
Alcohol Y or N , How much: _____
Tobacco Y or N , How much: _____

Supplements: _____

Medications: _____

Purpose of Visit: (if multiple, please rank them in order of importance)

_____

_____

_____

_____

_____

_____