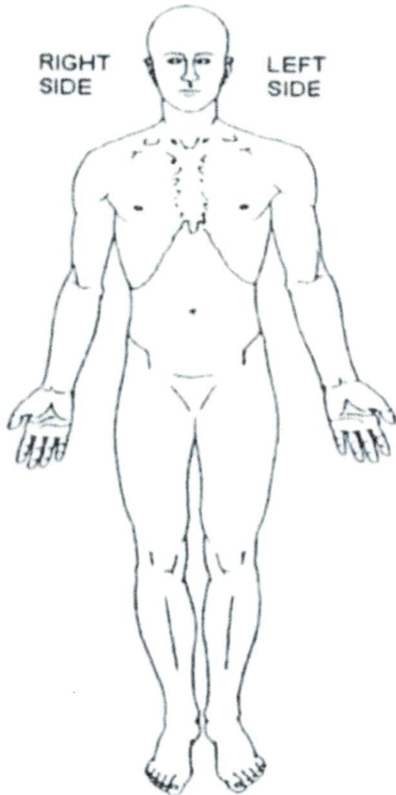
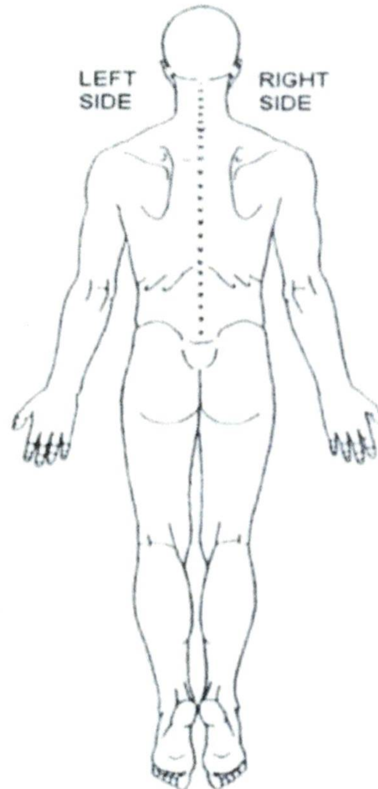
SHADE THE AREAS OF YOUR BODY WHICH YOU WOULD LIKE THE DOCTOR TO TREAT.





When did your primary area of complaint begin?________________________
How?____

PatientSignature:______________________ Date:______________________

Office Use Only: **Functional Indexes:**

___ NDI Score:_________ FL: minimal moderate severe crippled bedbound/exag
___ ODI Score:_________ FL: minimal moderate severe crippled bedbound/exag
____DASH Score:_________ FL: minimal moderate severe crippled bedbound/exag
____LEFS Score:_________ FL: Very minimal Minimal moderate Severe

Name:____________________ **Nickname:**__________ ID#: :
Name changes: ________________________________
Address:
Addresschanges: City: State: Zip:
SS#:____________ Sex:

Spouse Name: ________________________phone #: ____________________

HomePhone: changes (_______) ________-__________
Cell Phone: changes (_______) ________-__________

Work Phone: changes (_______) ________-__________

Email Address: ____________________________________

Consent for mail, messages, and text:

I hereby authorize Kenneth Boscher DC; Conyers Family Chiropractic Center to mail reminders, birthday cards, newsletters, and special event notifications to my mailing address, including postcards.
I hereby authorize Kenneth Boscher DC; Conyers Family Chiropractic Center to contact me by any telephone numbers, email addressees, or other contact points provided by me or on my behalf by text message, email, or by telephone for reasons related to the services I received at Kenneth Boscher DC;Conyers Family Chiropractic Center or payment for the services I received including but not limited to debt collection purposes. Including appointment reminders. I authorize messages to be left on voicemail system or answering machine to number provided above.

If you do NOT wish to have us leave messages or send you text please check below.

❑ **I DO NOT authorize the above numbers to be utilize to leave messages.**
❑ [illegible]

❑Google Reviews ❑Facebook ❑ Our Webpage ❑PPO/HMO listing ❑Phone book
❑Friend________________ ❑ Family __________________ QPatient________________
❑Doctor__________________ ❑ Office sign ❑Other____________________

Emergency Contact______________________________ **Phone:**_______________

Consent to Release Medical Information to a Spouse, Family Member, Significant other, or Doctor

Tell us with whom we may discuss your protected Health information (name and relation: example: Jane Doe, wife).

1)________________________ 2)______________________
3)________________________ 4)______________________
❑ [illegible]

I recognize my responsibility to pay for all services. Charges for all minors are the responsibility of the parent, guardiai or individual presenting the child for treatment. For any balance on your account we will mail you bills or call you.

Patients Signature: ____________________________ **Date:** ____________
Guardians Signature: ____________________________ **Date:** ____________

ID#
DOA:

Primary Care Physician Name:__________________ Phone:__________________________
Have you had any recent X-rays?_____ If so where?__________________________________
Have you ever seen another chiropractor? DYes DNo If yes, date of last visit: ___/___/____

List all Current Medications with Dose/Frequency

(if you brought a list please give to the front desk)

List all Allergies with Reaction

List all Surgeries with date

Work Status: Working Full Time, Part time, unemployed, homemaker, disabled, Unable to work due to reason of visit
Occupation: ________________________________
Employer:____________________________________
Work Activity: (Circle One) Sitting, Standing, Light Labor, Heavy Labor
Job Duties:____

Please check all that you that apply to you:

❑Stroke:Last Stroke Date: ___/___/__ ^Medically implanted devices: Current/had in past
❑Seizure:Last Seizure Date:___/___/__ DTaking blood thinners: Current/had in past
❑Rheumatoid arthritis ❑Aneurysm: Current/had in past
❑Osteoporosis

Are you Pregnant or think you may be pregnant? ❑ Yes _____ wks ❑ NO ❑ N/A

As a part of the analysis, examination, and treatment, I am consenting to the above procedures as well as spinal manipulative therapy. By signing below I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended.

PatientSignature:____
Date:______________________________

ID#

DOA:

Informed consent for Chiropractic Care

A patient, in coming to the Chiropractor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, analysis, and treatment. The Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contraindicated. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

I understand that if I am accepted as a patient by a chiropractor at Conyers Family Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization regarding care being provided in an "open-bay" therapy and "open-bay" adjusting room.

It is the design of this office to provide therapy care and adjustments in an "open-bay" therapy environment. An "open-bay" approach involves the patient receiving therapy care in an open area with other patients. As a result, patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting report of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the finds of matter related in an "open-bay" environment are incidental matter, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization. If you choose not to have therapy or an adjustment in an "open-bay" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Kenneth Boscher DC; Conyers Family Chiropractic Center or your relationship with our staff.

Acknowledgement of Privacy Rights.

By signing the below I acknowledge that I am aware of the "Notice of Patients Rights and Privacy Protections under Federal Privacy Laws (HIPAA)" and was offered a copy. A full copy of this office's HIPAA Compliance Manual is available upon request. We may use or share your medical information with personnel involved in your care at Kenneth Boscher DC; Conyers Family Chiropractic Center. We also my disclose your medical information to people outside our office, such as your insurance company, attorney, or imaging center.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights. I do hereby consent to the use of my health information in a manner consistent with Notice of Patients Rights and Privacy Protections under Federal Privacy Laws (HIPAA) , the HIPAA Compliance Manual, State law and Federal Law.

Patients Signature: ______________________________ **Date:** __________

Guardians Signature: ______________________________ **Date:** __________

ID#
DOA:

Kenneth Boscher DC
FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

TOS DISCOUNT

This discount is for patients who pay for their visit in full at the time of service, and that we do not file insurance for. Payments can be in any form: check, cash, credit card, debit card, etc. Our TOS discount is available to all patients. All have an equal opportunity to participate in reducing health care costs and to share in the savings. The criterion for the discount is that payment be made at the time of service and that no insurance will be filed from our office. This is a way for us to share the reduction of overhead we receive by not having to bill insurance for patients and by not having to wait for payment. If you have insurance and you decide to take advantage of the TOS discount, remember that we must not incur administrative costs. This means that you, the patient, are responsible for filing your own insurance. If at any time you wish to have us file insurance for you the TOS discount will no longer apply. If you do not pay at time of service and we have to bill you the discount will no longer apply. (Initial) ____________

GROUP OR INDIVIDUAL INSURANCE

When possible, we will verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

Insurance Deductible: ______________________ Deductible as yet unsatisfied: __________
Co-Insurance/Copay: ______________________ Visit Limit ______________________

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you or if you change attorneys. Although you are ultimately responsible for your bill, we may wait for settlement of your claim for up to six months after your care is completed with proper representation. Once the claim is settled any fees for services are due immediately. All Medical Pay payments need to be paid to this office. (Initial) ____________

I have read and understand the payment policy of Kenneth Boscher DC I understand that if my insurance does not respond within 60 days the balance on my account will be due and payable immediately. Unpaid patient balances will be sent to Darnel Quick Recovery after *4* months.

____

Patient's signature (or guardian if patient is a minor) Date Witness Date