NEW PATIENT INFORMATION SHEET

Date:_____

Last Name: _____**First:** _____**M.I.:** _____

Status: __*Married* __*Single* __*Widowed* __*Divorced* __*Other*

SSN #: _____ **Birth Date:** _____ **Sex:** *Male Female*

Address: _____**City:** _____

Ste/Apt #: _____**State:** _____**Zip:**_____ **Phone Number:** _____

Permission to contact you about appointments: *Yes No* **Email:** _____

Emergency Contact: _____**Phone:** _____

EC Email: _____**Relationship:** _____

Is this a work-related injury? *Yes No* **If yes, Date of Accident:** _____**Time:** _____*am / pm*

Is this an auto accident? *Yes No* **If yes, Date of Accident:** _____**Time:** _____*am / pm*

PATIENT QUESTIONNAIRE

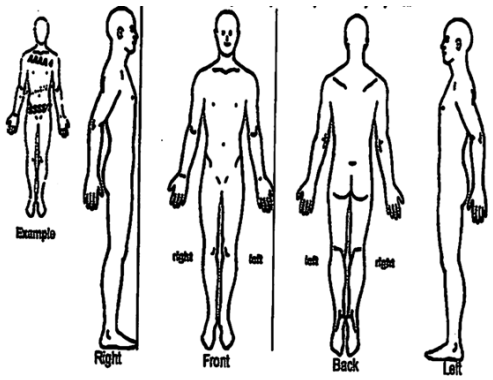
1. **Have you ever had chiropractic care before?** *Yes No*
   - **Where:** _____
   - **When:** _____
2. **How bad is your pain? (**1 being no pain, 10 being extreme pain)
   - **Neck:** _____
   - **Arm:** *Right* _____ *Left* _____
   - **Back:** _____
   - **Leg:** *Right* _____ *Left* _____

Major Complaint / Reason for visit

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description symbol: ** Numbness – NNNN * Pins and needles – PPPP * Burning – BBBB * Aching – AAAA * Stabbing – SSSS*

Circle any areas not represented by a symbol



Please describe your symptoms and mark the chart.

3. **When did this condition start?** _____
    - **What caused it?** _____
4. **Did the pains start gradually or all at once?** _____
    - **Is the condition staying the same, improving, or getting worse?** _____
    - **Is the pain constant or does it come and go?** _____
    - **Does it interfere with your work, sleep, daily routine?** _____
5. **What makes your condition better or worse?** _____
6. **Have you tried treating this problem before? If so, how?** _____
   _____
7. **Have you had any surgery? If so, what and why?** _____
   _____
8. **Have you ever had an auto accident or work injury?** _____
    - **Did you receive treatment?** _____
9. **Have you had any medical problems? If so, please explain.** _____
   _____
10. **Have you had a flu shot within the past 6 months?** *Yes No*
11. **Have you had pneumonia shot within the last 12 months?** *Yes No*
12. **Do you exercise?** *None Moderate Daily Heavy*
13. **Your work activity:** *Sitting Standing Light Labor Heavy Labor*
14. **Your habits:** *Smoking ___#per/day Alcohol ____#Drinks per week High Stress Level ___*

Height _____

Weight _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

OFFICE POLICIES & PATIENT RESPONSIBILITIES

Insurance Responsibility

Patients are responsible for understanding their insurance benefits before receiving services. Insurance verification provided by our office is a courtesy and is not a guarantee of payment.

Patients are responsible for:

- Eligibility and coverage
- Deductibles and copays
- Visit limitations
- Referrals and prior authorizations

Any services not covered by insurance remain the patient's responsibility. If services are denied due to lack of referral, authorization, or eligibility, the patient is financially responsible.

Appointment Policy

Standard office visits are scheduled in 15-minute increments. Appointment times are reserved specifically for each patient. To maintain clinic flow and respect all patients' scheduled times, we are unable to extend appointment times due to late arrival.

Late Arrival Policy

- Up to 5 minutes late: Appointment may proceed at provider discretion.
- More than 7 minutes late: Appointment will be rescheduled.

Cancellation & No-Show Policy

Please provide at least 24 hours' notice for cancellations or rescheduling.

A no-show or cancellation within 4 hours of the scheduled appointment may result in:

- First and Second Occurrence (within 6 months): $50 fee
- Third Occurrence (within 6 months): Possible dismissal from the practice

Payment Policy

- Payment is due at the time of service unless prior arrangements have been approved.
- Copays, deductibles, and self-pay fees are due at check-in.
- Outstanding balances may prevent future appointment scheduling.
- Payment plans must be arranged and approved in advance.

Patient Conduct Policy

Our office maintains a **zero-tolerance policy** for disrespectful or abusive behavior toward staff or providers.

Unacceptable behavior includes, but is not limited to:

- Verbal abuse or yelling
- Aggressive or threatening behavior
- Harassment or discriminatory language

Consequences may include:

- Immediate termination of the visit
- Dismissal from the practice
- Law enforcement involvement if necessary

Communication Policy

- Appointment reminders are provided as a courtesy and are not guaranteed.
- Failure to receive a reminder does not excuse a missed appointment.
- Patients are responsible for keeping their contact information current, including:
  - Phone number
  - Email address
  - Mailing address
- Patients must notify the office promptly of any insurance changes.

Patient Signature: _____

PATIENT RESPONSIBILITY, FINANCIAL AGREEMENT & EXAM POLICY

AUTHORIZATION FOR CARE

Patient Initials: _____

I voluntarily consent to chiropractic examination, treatment, and related therapies provided by the doctors and staff of Accurate Chiropractic Associates, LLC. I understand that treatment recommendations are based upon examination findings, clinical judgment, and my individual healthcare needs. I authorize the doctors and staff to provide chiropractic services and related procedures deemed appropriate during the course of my care. I understand that I may refuse treatment or request additional information regarding my care at any time.

MEDICAL RECORDS & RELEASE OF INFORMATION

Patient Initials: _____

I understand that Accurate Chiropractic Associates will maintain my medical records in accordance with applicable federal and state laws.
I authorize Accurate Chiropractic Associates to use and disclose my health information as necessary for:

- Treatment and coordination of care
- Insurance billing and payment
- Healthcare operations
- Referrals to other healthcare providers
- Requests from insurance carriers for claim review
- Legal or regulatory requirements as permitted by law

I understand that records may be transmitted electronically, verbally, or in written form when necessary for the purposes listed above.
I understand that my medical records may be retained and destroyed in accordance with applicable record retention laws and office policy.

INSURANCE RESPONSIBILITY AGREEMENT

Patient Initials: _____

I understand that health insurance is a contract between myself and my insurance carrier.
As a courtesy, Accurate Chiropractic Associates may verify insurance benefits; however, verification of benefits is not a guarantee of payment or coverage.
I understand that I am responsible for:

- Knowing my insurance benefits
- Determining whether chiropractic services are covered
- Obtaining referrals when required
- Obtaining prior authorizations when required
- Understanding deductibles, copays, coinsurance, visit limits, and exclusions

I understand that any services not covered, denied, reduced, or delayed by my insurance carrier remain my financial responsibility.
If my account becomes delinquent and is referred for collection services, I understand that I may be responsible for any allowable collection costs, court costs, attorney fees, or related expenses as permitted by law.

PAYMENT RESPONSIBILITY

Patient Initials: _____

Payment is due at the time services are rendered unless other arrangements have been approved in advance.
I understand that:

- Copays, deductibles, coinsurance amounts, and self-pay fees are due at the time of service.
- Failure to maintain a current account balance may affect future scheduling privileges.
- Returned checks may be subject to applicable fees.

EXAM, RE-EXAM & NEW PATIENT POLICY

Patient Initials: _____

I understand that chiropractic treatment recommendations are based upon my current condition and examination findings.
For patient safety and proper documentation, I understand that a re-examination may be required when there has been a significant change in my health status, condition, symptoms, or treatment history.
A re-examination is required if:

- I experience a fall, slip, trip, or other injury.
- I am involved in a motor vehicle accident.
- I sustain a work-related injury.
- I am hospitalized or receive emergency medical care related to my condition.
- The doctor determines that my condition has materially changed.

Additionally:

Medicare Patients

- Office Visit: Within 3 months of previous visit
- Re-Exam: More than 3 months since previous visit
- New Patient Examination: More than 2 years since previous visit

Private Insurance & Self-Pay Patients

- Office Visit: Within 6 months of previous visit
- Re-Exam: More than 6 months since previous visit
- New Patient Examination: More than 3 years since previous visit

I understand that applicable examination or re-examination fees may apply.

EXAMINATION FEES

Patient Initials: _____

Medicare / Medicare Advantage

- New Patient Examination: $100.00
- Re-Examination: $55.00

Private Insurance

- New Patient Examination: $50.00
- Re-Examination: $25.00

Self-Pay Patients

- New Patient Examination: $174.00
- Re-Examination: $129.00

Fees are subject to change. Current fees will be communicated prior to service when possible.

PATIENT ACKNOWLEDGMENT

I certify that I have read, understand, and agree to the policies contained within this Patient Responsibility, Financial Agreement, and Exam Policy.
I understand that I am financially responsible for services rendered and that my signature indicates my acceptance of these terms.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Witness (Office Use Only): _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

PURPOSE OF CHIROPRACTIC CARE

Chiropractic care focuses on the evaluation, diagnosis, and treatment of conditions affecting the musculoskeletal and nervous systems.
Treatment may include, but is not limited to:

- Chiropractic adjustments/manipulation
- Mobilization techniques
- Therapeutic exercises
- Soft tissue therapies
- Electrical muscle stimulation
- Ultrasound therapy
- Heat and cold therapies
- Acupuncture (when applicable)
- Other supportive therapies deemed appropriate by your provider

During treatment, you may hear or feel a "click" or "pop" associated with movement of a joint. This is a common occurrence during chiropractic adjustments.

EXPECTED BENEFITS

Potential benefits of chiropractic treatment may include:

- Reduction of pain and discomfort
- Improved joint mobility and function
- Improved posture and movement patterns
- Reduced muscle tension
- Improved quality of life and daily function

Because each patient responds differently, no specific results can be guaranteed.

RISKS OF CHIROPRACTIC TREATMENT

As with any healthcare procedure, certain risks may be associated with chiropractic care.
Common temporary reactions may include:

- Mild soreness or stiffness
- Fatigue
- Temporary increase in symptoms
- Muscle tenderness

These symptoms typically resolve within several days.
Rare complications may include:

- Muscle strain or ligament sprain
- Aggravation of a pre-existing condition
- Rib injury
- Joint injury or dislocation
- Disc injury or worsening of disc-related symptoms
- Nerve irritation or injury
- Fracture

Extremely rare complications associated with cervical (neck) manipulation may include injury to blood vessels supplying the brain, which could result in stroke, permanent neurological impairment, or death.
Current scientific literature suggests that such complications are extremely rare; however, no healthcare procedure is entirely without risk.

ALTERNATIVE TREATMENT OPTIONS

Alternative treatment options may include:

- Observation and no treatment
- Over-the-counter medications
- Prescription medications
- Physical therapy
- Medical evaluation and management
- Pain management procedures
- Surgical consultation or intervention

Each alternative carries its own risks and potential benefits.

RISKS OF DECLINING TREATMENT

Choosing not to receive treatment may result in:

- Continued pain or discomfort
- Decreased mobility or function
- Progression of the condition
- Development of chronic pain patterns
- Increased difficulty with future treatment and rehabilitation

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PATIENT RESPONSIBILITIES

To help ensure safe and effective care, I agree to:

- Provide accurate and complete health information.
- Inform my provider of any changes in my health status.
- Report any injuries, falls, accidents, hospitalizations, or new symptoms.
- Follow recommended treatment plans and home care instructions.

ACKNOWLEDGMENT AND CONSENT

I acknowledge that:

- The nature and purpose of chiropractic treatment have been explained to me.
- The potential risks, benefits, and alternatives have been explained to me.
- I have had the opportunity to ask questions and have received satisfactory answers.
- No guarantees or assurances regarding the outcome of treatment have been made.
- I understand that I may withdraw my consent and discontinue treatment at any time.

By signing below, I voluntarily consent to chiropractic examination, treatment, and related procedures performed by the providers and staff of Accurate Chiropractic Associates, LLC.

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT, AUTHORIZATION TO RELEASE INFORMATION & AUTHORIZED CONTACTS

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Accurate Chiropractic Associates, LLC's Notice of Privacy Practices. Patient Initials: _____

I understand that the Notice of Privacy Practices explains:

- How my protected health information (PHI) may be used and disclosed.
- My privacy rights regarding my medical information.
- How I may obtain access to my records.
- How I may request restrictions or amendments to my health information.

I understand that Accurate Chiropractic Associates reserves the right to revise its Notice of Privacy Practices in accordance with applicable laws and regulations.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Initials: _____

I authorize Accurate Chiropractic Associates, LLC to use and disclose my protected health information as necessary for:

- Treatment and coordination of care
- Insurance billing and claims processing
- Healthcare operations
- Referrals to specialists or other healthcare providers
- Diagnostic testing and imaging referrals
- Payment collection activities
- Other uses and disclosures permitted or required by law

I understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by submitting written notice to the office.
- Revocation will not affect disclosures made prior to receipt of the written revocation.
- Information disclosed to authorized recipients may no longer be protected under federal privacy regulations.
- Refusal to authorize certain disclosures may affect the office's ability to coordinate care, process insurance claims, or provide certain services.

AUTHORIZED CONTACTS & APPOINTMENT MANAGEMENT

I authorize the following individual(s) to receive information regarding my care and/or assist with management of my appointments.

Authorized Individual #1

Name: _____ Date of Birth: _____

Relationship: _____ Phone Number: _____

Information Authorized for Release

Unless otherwise limited below, the individuals listed above may:

☐ Schedule appointments
☐ Cancel or reschedule appointments
☐ Receive appointment reminders
☐ Discuss treatment recommendations
☐ Discuss progress of care
☐ Discuss billing and insurance matters
☐ Receive copies of records when authorized
☐ Discuss all healthcare information

Restrictions or Limitations (Optional)

REVOCATION OF AUTHORIZATION

Patient Initials: _____

I understand that:

- I may revoke this authorization at any time in writing.
- Revocation will not affect actions already taken based upon this authorization.
- This authorization shall remain in effect until revoked by me in writing.

PATIENT ACKNOWLEDGMENT

I certify that:

- I have read and understand this document.
- I have had the opportunity to ask questions.
- My questions have been answered to my satisfaction.
- The information provided is accurate and complete.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____