NEW PATIENT INFORMATION SHEET

ACCURATE CHIROPRACTIC ASSOCIATES, LLC

800 AIRPORT ROAD, STE 103, MILFORD, DE 19963 | 302-422-0622 / FAX 302-424-8448

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

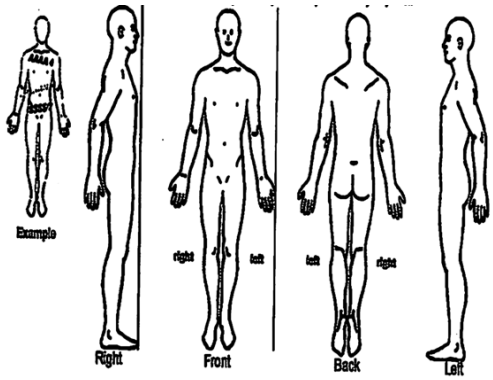
1. **Have you ever had chiropractic care before?** *Yes No*
   - **Where: _____**
   - **When: _____**
2. **How bad is your pain? (**1 being no pain, 10 being extreme pain)
   - **Neck: _____**
   - **Arm:** *Right _____ Left _____*
   - **Back: _____**
   - **Leg:** *Right _____ Left _____*

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



<u>Please describe your symptoms and mark the chart.</u>

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: _____

No Show Agreement

Accurate Chiropractic Assoc.

800 Airport Rd, Milford, DE 19963

As of July 28th, 2023, Accurate Chiropractic has created the new terms for No Shows and Cancellations as follows:

If you cancel within 4 hours before your scheduled appointment, do not show up, or do not inform us, it will be marked down for the following.

- The first and second no show/cancellation within 6 months will be followed by a $50 charge added to your ledger.
- The third no show/cancellation within 6 months will be considered **Termination** of contract. We will send out a letter and or email stating the termination and include your final statement with your remaining balance due.

Treatment will only begin after this acknowledgment is signed and dated. Failure to do so will result in immediate cancellation of services. Charges and terms may be subject to change based on situation. If you would like text message or email reminders, please let us know and we will set that up.

I, _____ acknowledge that I will call and let the office of Accurate Chiropractic know if I will be unable to attend my appointment at the scheduled time.

We appreciate your patience and understanding of our new terms. Thank you.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Accurate Chiropractic Associates, LLC

Dr. Garrett Herring / Dr. Eric Ledford

800 Airport Road, Suite 103, Milford, DE 19963

302-422-0622 / FAX 302424-8448

PATIENT RESPONSIBILITY AGREEMENT

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I authorize the above-named doctor/doctors/clinic to administer treatment to me and perform therapy. I authorize such additional procedures, as the above-named doctor/doctors/clinic may consider desirable based on findings and determinations made during the course of treatment. Also, I authorize the above-named doctor/doctors/clinic to consult with other professionals concerning my care and treatment.

I certify that I have read and understand the Authorization for chiropractic Treatment and that I am aware of the possible risks and complications of chiropractic treatment. ***INITIALS***:_____

MEDICAL RECORDS

I understand and agree that this chiropractic office will maintain the privacy of my medical records. I understand and agree that from time to time it may be necessary for this chiropractic office to transmit copies of my records to my insurance carrier, other health care professionals, and the legal profession for routine use and disclosure. I authorize this office to transmit my records for such a review if necessary. The transmission of my records may be by oral communication, paper communication, and/or by electronic communication. I understand and agree that after a period of seven years inactivity at this office my medical records my be destroyed. ***INITIALS***:_____

Minors Accompanied by the Parent/Legal Guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.
Unaccompanied Minors: Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or treatment may be denied. The parent or legal guardian is responsible for full payment at time of service.

EXAM AGREEMENT

I understand and agree that if I do not come for treatment for longer than 6 months (Private or Non-Medicare Insurance or Cash Patient) or 3 months (Medicare) that I am required to be a Re-Exam and be treated and billed as such. I understand and agree that if I fall, slip, trip, have an accident (car, work, etc.) or go to the hospital I am required to be a Re-Exam and be treated and billed as such. I understand and agree that if I do not come for treatment for longer than 3 years (Private or Non-Medicare Insurance or Cash Patient) or 2 years (Medicare) that I am required to be a New Patient and be treated and billed as such. ***INITIALS***:_____

PATIENT INSURANCE / BILLING AGREEMENT

1. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that this chiropractic office will accept payment from my insurance carrier and prepare any necessary reports and forms to assist me in collecting from the insurance carrier. Any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for whatever charges are not paid by my insurance carrier. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand and agree that if my account is turned over to a collection agency that I will be responsible for all court fees and the percentage charged by the collection agency. **Initial_____**
2. I understand that I am responsible for knowing if my insurance requires me to have a referral or authorization for treatment and I am responsible in obtaining such things. I understand that I am responsible for finding out what all deductibles, co-pays and or fees are required from my insurance carrier. I understand that I alone am responsible for knowing if my insurance carrier covers Chiropractic care. **Initial_____**
3. I understand and acknowledge that the following fee schedule is required of my Exam today and any Exam in the future due to insurance carriers not covering Exam Fees. **Initial_____**
    - New Patient Fees
        - Medicare or Medicare Advantage - $100.00
        - Private or Non-Medicare - $50.00
        - Cash Patients - $174.00
    - Re-Exam Fees
        - Medicare or Medicare Advantage - $55.00
        - Private or Non-Medicare - $25.00
        - Cash Patients - $129.00
4. I understand and acknowledge that the following attendance schedule is required of me due to my insurance policy and policies of the chiropractic office. **Initial_____**
    - Medicare or Medicare Advantage
        - Within 3 months of last visit – Office Visit
        - Past 3 months of last visit – Re-Exam (See Fee Schedule for Charge)
        - Past 2 years of last visit – New Patient (See Fee Schedule for Charge)
    - Private or Non- Medicare / Cash Patients
        - Within 6 months of last visit – Office Visit
        - Past 6 months of last visit – Re-Exam (See Fee Schedule for Charge)
        - Past 3 years of last visit – New Patient (See Fee Schedule for Charge)

ACCURATE CHIROPRACTIC ASSOCIATES, LLC

Informed Consent to Chiropractic Treatment

(Possible Risks & Complications)

The nature of chiropractic treatment*:* The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry/wet hydrotherapy, massage or acupuncture may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment/manipulation. Complications although very rare could include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as very rare about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be ever further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered very rare.

Other treatment options which could be considered may include the following:

- *Over the counter analgesics:* The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care:* Typically, anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs can include numerous adverse undesirable side effects and patient dependence in significant number of cases.
- *Hospitalization:* in conjunction with medical care adds a risk of exposure to virulent communicable disease in significant number of cases.
- *Surgery:* in conjunction with medical care adds a risk of an adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Despite the additional risks noted with the other treatment options, medical care, analgesics, meditation, hospitalization and surgery may be necessary in certain cases. These options may be used in conjunction with your chiropractic care under the direct of your medical doctor.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delays of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment and the possibility and probability of risks. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

PATIENT SIGNATURE: _____ ***DATE:*** _____

PATIENT PRINTED NAME: _____

Date: _____

ACCURATE CHIROPRACTIC ASSOCIATES
800 AIRPORT RD, STE 103, MILFORD DE 19963
302.422.0622 | FAX 302.424.8448

Authorization to Release Health Information & Appointment Management Consent

Patient Name: _____ Date of Birth: _____
Phone Number: _____ Email: _____

In accordance with HIPAA regulations, this form allows you to designate individuals who may receive information about your medical care and/or assist in managing your appointments at Accurate Chiropractic.

I authorize Accurate Chiropractic to release information to and/or allow the following individual(s) to make changes to my appointments:

1. Name: _____
   DOB: _____
   Relationship: _____
   Phone: _____
2. Name: _____
   DOB: _____
   Relationship: _____
   Phone: _____

(You may write "N/A" if you do not wish to list additional names.)

This includes, but is not limited to:

- Scheduling, canceling, or rescheduling appointments
- Discussing treatment plans and progress
- Discussing billing and insurance matters
- Accessing relevant medical records or health information

I understand that:

- I may revoke this authorization at any time in writing.
- Revocation will not apply to information already released in reliance on this form.
- This authorization will remain in effect until revoked by me in writing.

Patient Signature: _____Date: _____

Accurate Chiropractic Associates, LLC
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963
302-422-0622 / Fax 302-424-8448

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I _____, hereby authorize Accurate Chiropractic Assoc., LLC (the "Practice") to use and/or disclose to *other health care professionals/physicians, to appropriate third party payers, to practice staff for insurance/billing procedures, or anyone I so designate to receive* the following specific health information: *copies of my medical records, billing information.*

2. I understand that this authorization is valid until I revoke this authorization.

3. I understand that the purpose or use of this disclosure I am granting is to *provide information for treatment, payment and health care operations* .

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office may receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare may be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it if so requested.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid as of ____/____/____, the date I have signed below.

_____ _____
Name of individual (Printed) Signature of individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if minor)

Effective 7-19-2010

Witness:_____

Accurate Chiropractic Associates, LLC
Dr. Garrett Herring/Dr. Eric Ledford
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963-9803
302-422-0622 /fax 302-424-8448

Patient Request for Records

I, _____, do hereby authorize the release of my x-rays records, reports, medical records, reports or copies of such from_____ and request that they be transferred to:

Dr. _____
Address: 800 Airport Road, Suite 103
Milford Medical Center
Milford, DE 19963-9803
Fax 302-424-8448

Date: _____

Patient's Signature: _____

Date of records: _____

Date records sent: _____

Thank you for your time and attention regarding this matter.