ANDERSON CHIROPRACTIC CENTER
131 W. HOLLY SPRINGS ROAD
HOLLY SPRINGS, NC 27540
PHONE: 919-552-0751
FAX: 919-552-0891
WWW.ANDERSONCHIROPRACTICCENTER.COM
INFO@ANDERSONCHIROPRACTICCENTER.COM

ANDERSON
chiropractic center

General Information:

First Name: _____

Middle Initial: _____

Last Name: _____

Suffix: _____

Called Name: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Email Address: _____

Marital Status: ***(Circle One)*** Single Married Other _____

Birthdate: _____/_____/_____ Male Female

Last 4 of Social Security: XXX-XX-_____

Referred By: _____

Work Status: Employed Full-time student Part-time student

Patient is the: ***(Circle One)*** Self Husband Wife Child ….of Insured

Primary Insured's Information (***Skip if you are primary***)

First Name: _____

Middle Initial: _____

Last Name: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Last 4 of Social Security: XXX-XX-_____

Birthdate: _____/_____/_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read and initial:

_____I acknowledge that I was provided the opportunity to review a copy of Anderson Chiropractic Center's Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for six (6) years unless I provide written notice to revoke this authorization.

_____ I understand that the staff at Anderson Chiropractic Center may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

_____ I understand that Anderson Chiropractic Center utilizes phone calls, text messaging and e-mail messaging for appointment reminders and or missed appointments. I authorize the staff at Anderson Chiropractic Center to contact me with these reminders and leave a voice mail message if necessary.

_____ ____/____/_____

Patient Name Printed Date

_____

Patient Signature

_____

Parent/ Guardian Name & Relationship Printed (If under 18)

_____

Parent or Guardian Signature (If under 18)

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INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

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 as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles.

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic neurological testing
- Muscle strength testing
- Postural analysis
- Radiographic studies
- Hot/cold therapy
- Electrical Muscle Stim
- Ultrasound Therapy

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, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck 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.

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.

Other treatment options for your condition 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 chose 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.

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.

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.

Patient Name (please print):_____ Date:___/____/_____

Patient Signature:_____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

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AUTHORIZATION OF ASSIGNMENT AND LIEN

I hereby authorize and direct any and all insurance carriers, attorneys, and/or other legal entities which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present or future to pay directly and exclusively in the name of Anderson Chiropractic Center such sums as may be owing to Anderson Chiropractic Center for charges incurred by me at the office relating to my condition.

I further grant a lien to Anderson Chiropractic Center with respect to my charges. This lien should apply to all payers and to the full extent permitted by law. For the purposes of this document benefits shall include, but not be limited to proceeds for any settlement, judgment or verdict as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina; I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers to facilitate collection under this Assignment and Lien.

I further authorize and direct all payers to release to Anderson Chiropractic Center any information regarding any coverage or benefit which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers.

I hereby authorize Anderson Chiropractic Center to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of an account relating to me. I further authorize Anderson Chiropractic Center to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me.

I hereby authorize and direct my attorney to disclose upon the request of Anderson Chiropractic Center, any settlement amounts or any offers made on my case from any potential payers.

I understand that I remain personally responsible for the total amounts due to Anderson Chiropractic Center for their service(s). This Assignment and Lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Anderson Chiropractic Center for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Anderson Chiropractic Center and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print):_____ Date:_____/_____/_____

Patient Signature:_____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

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Health Information:

Patient Name : _____

Past Treatments:

Have you ever been to a chiropractor? ☐ Yes ☐ No *(If no, skip ahead.)*

- How long has it been since your last adjustment? _____
- Did your previous chiropractor adjust your full spine (neck, mid-back & lower back) or focus on specific areas?

  _____
- Did your previous chiropractor use their hands or the activator (device) to adjust your spine? _____
- When was the last time you had x-rays of your spine? _____

Past and Present Health Conditions:

Do you have any health issues that require medication or monitoring? ☐ Yes ☐ No *(If no, skip ahead.)*

- Please list any medications *and what it is for*: _____

  _____

  _____

Allergies:

Do you have any allergies? ☐ Yes ☐ No *(If no, skip ahead.)*

- Please list your allergies: _____

  _____

Vitamins and Supplements:

Do you take vitamins or supplements? ☐ Yes ☐ No *(If no, skip ahead.)*

- Please list any vitamins or supplements you take: _____

  _____

Surgeries:

Have you had any surgeries? ☐ Yes ☐ No *(If no, skip ahead.)*

- Please list: _____

  _____

Family History:

Do your parents, siblings or children have any medical conditions that have to be medicated or monitored?

☐ Yes ☐ No *(If no, skip ahead.)*

- Please list: _____

  _____

Social History:

Do you drink alcohol? ☐ Yes ☐ No *(If no, skip ahead.)*

Do you use tobacco products? ☐ Yes ☐ No *(If no, skip ahead.)*

What do you do for a living? _____