total bodywork
CHIROPRACTIC

Personal Information

Name:			Date:
Address:			Apt #:
City:		State:	Zip:
Home Ph.:	Work Ph.:		Cell Ph.:
How would you like receive appointment reminders? (Please circle one) Call or Text			
D.O.B.:	Sex: M F		Marital Status: S M W D
Email:			
Employer:		Occupation:	
Address:			
City:		State:	Zip:
Who is your primary care physician?			Clinic name:
May we contact your primary care physician to discuss your visit? Y N			
Are you currently pregnant? Y N		If you are pregnant, may we contact your OB/GYN? Y N	
Who is your OB/GYN?			Clinic name:
How were you referred to our office?			
May we contact them to say thank you? Y N			
Number of children and their ages?			

Insurance Information

Who is the primary insured person:		
Policy ID #:	D.O.B.:	Policy holder employer:
Relationship to policy holder: Self Spouse Child Other		Flexible spending account? Y N

Emergency Contact

Name:		Relationship:
Home Ph.:	Work Ph.:	Cell Ph.:
Address:		
City:	State:	Zip:

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned claimant, hereby authorize the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this documentation authorizes total bodywork to submit claims for benefits, for services rendered or for services to be rendered without obtaining a signature on each and every claim to be submitted for me and/or my dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I hereby authorize my insurance company: _____ to pay and hereby assign directly to total bodywork all benefits, if any, otherwise payable to me for services as described on the detached forms, and I also agree to pay co-payments and/or deductibles.

I understand that I am financially responsible for all charges incurred and that any insurance benefits, when received by and paid to total bodywork will be credited to my account in accordance with the above assignment. I further acknowledge that verification of benefits is not a guarantee of payment from my insurance company.

Signature:	Date:

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE

*Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
*Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.
*Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
*Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No.2 June, 1993) estimate that the incidence of this type is stroke is 1 in 3 million upper cervical adjustments.
*Other problems – There are occasional other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor immediately.

If during the course of chiropractic examination and/or treatment we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I have read and fully understand the above statements.

Signature:	Date:

PREGNANCY WAIVER

I hereby acknowledge that the doctors of total bodywork have informed me, prior to being x-rayed, the possible risks and consequences of receiving x-rays during pregnancy. I have stated on my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient:	Date:
Signature of Patient or Authorized Representative:	
Witness:	Date:

SOCIAL HISTORY

Do you drink alcoholic beverages? Y N If so, how much per week?
Do you use any tobacco products? Y N Do you smoke? Y N If so, packs per day?
Do you take vitamin supplements? Y N If so, please list:
Do you consume caffeine? Y N If so, how much per day?
Do you exercise? Y N If yes, what is the frequency and type of exercise?
What position do you sleep in? Side Stomach Back

Height:	Weight:

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting: Sitting: Bending: Working at a computer:

	Doctor Initials

FAMILY HISTORY

Father: living deceased current age: Mother: living deceased current age:

Cause of death and age at if deceased: Cause of death and age at if deceased:

I am an adopted child and know little of my birth parents of family: Y N

Do you have any family members who suffer from the same condition you do? Y N

If so, please list:

Family Diseases (circle applicable, indicate whether family member is **F**ather **M**other **S**ister **B**rother

Tuberculosis	Cancer	Mental Illness
Diabetes	Asthma	Heart Disease
Stroke	Kidney Disease	Lung Disease
Arthritis	Liver Disease	Other:

Remarks:

	Doctor Initials

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from (Please circle all that apply)

Broken or Fractured Bones	Osteoarthritis	Eating Disorder	Ulcers
Circulatory Problems	Epilepsy	Alcoholism	Coughing Blood
Rheumatoid Arthritis	Pace Maker	Drug Addiction	Excessive Bleeding
Seizures/Convulsions	Cancer	Gall Bladder	Asthma
A Congenital Disease	Diabetes	Mental Illness	Heart Disease
Lung Disease	Liver Disease	Depression	Kidney Disease

Do you have a history of stroke or hyper/hypotension? Y N

Have you had any major illness, injuries, falls, auto accidents or surgeries? Y N

Women, please include information about childbirth (include dates):

Have you been treated for any health condition by a physician in the last year? Y N

If yes, describe:

What medications are you taking?

Do you have allergies of any kind? Y N If yes, please describe:

Please list any other health problems you have, no matter how insignificant they may be:

	Doctor Initials

What are your chief complaints today?

What goals are you hoping to achieve with chiropractic care? (Please choose one)

- ☐ Pain Relief
- ☐ Pain Relief & Correction of Problem
- ☐ Pain Relief & Correction of Problem & Prevention of Future Problems
- ☐ I want to call when I want to get adjusted

Patient Signature:	Date:
Guardian's Signature Authorizing Care:	Date:

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Signature:	Date:

If the patient is a minor or under guardianship order as defined by State Law:

Parent / Guardian Signature:	Date:

(Circle One Above, Parent or Guardian)

For further information regarding this notice, please contact our office.

total bodywork Policies

By signing below, you are acknowledging that you have read, understand and agree to the total bodywork policies.

- ADJUSTMENTS ARE NOT DONE ON THE FIRST VISIT and diagnostic tests may be performed off-site.
- I authorize total bodywork to send my x-rays for an outside read, if needed. I understand that by doing this I may incur a fee in the office or with the company performing the outside read. I agree to allow the third party to bill my insurance for this service or I will pay the fee this office incurs for this service.
- I understand the insurance coverage explained to me is NOT a guarantee of benefits, and I am responsible for any amount that my insurance company does not cover.
- If we can not verify benefits on your first visit because of problems with your insurance company, examples: offices closed, their computer is down, etc, you will be responsible to pay the cash price and you will be refunded any amount due on your second visit.
- Patients are required to purchase electrodes for passive therapy at $9 per set and that each set lasts approximately 10 to 15 uses.
- I understand that if I do not have insurance coverage or my insurance does not cover chiropractic, I am responsible for the time of service discount cash prices which are as follows: Non-pregnant patients $240 (includes x-rays of 1 body region), pregnant patients $180, children $170 (approximately 7 & under)
- I understand that I am responsible for all charges incurred at total bodywork including but not limited to supplements, products, services, and the 'no-call - no-show' policy.
- We enforce a 'no-call - no-show' policy, any patient missing an appointment without calling to cancel or reschedule 24 hours prior to the appointment will be charged a $25 fee.
- Because there are many patients with headaches seen in this office, and I agree to turn my cell phone off or set it to silent when I am at total bodywork.
- I understand that I will be charged a $30 returned check fee each time a check is returned unpaid and that it may be electronically debited from my account.
- I understand that I will be charged $30 for any chargeback fees on credit card transactions.
- I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.
- Payment in full is due at the time services are rendered.
- I understand that original x-ray films cannot be released and copies will be charged at a minimum of $50 for 2-films. Pictures can be taken, by you, if you request but we will need advance notice so the films can be pulled and ready for your next visit.
- If you are a Medicaid patient, please be advised that we do not accept Medicaid. You will be a private pay or cash patient and responsible for all charges incurred at this office.
- I give permission to any of the total bodywork staff to leave messages at any of the phone numbers I have listed via voicemail or whomever answers. I also give permission for any correspondence from total bodywork to be mailed to my home address or email.
- If I have not been seen in the office for over 3-months, a re-exam will be performed.
- If a letter of excuse is needed for my work/school, I should request it at the time of check-in.
- Treatment is performed in an open environment, inadvertent disclosure may occur to surrounding patients. If you have a situation to discuss privately, please let us know.
- PLEASE NOTE: ADJUSTMENTS ARE NOT DONE ON THE FIRST VISIT

Patient Signature:	Date: