



*Clouse Chiropractic Center
421 Barony Street, Suite #1
Moncks Corner, SC 29461
843-899-7383 phone
843-899-7379 fax*

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Home #: _____
Cell #: _____

Physical Address: _____ Mailing Address: _____

Occupation: _____ Employer: _____

Work #: _____ Work Address: _____

Age: _____ Birthdate: _____ SS #: _____

Marital Status: (circle) married single divorced widow separated

Spouse's Name: _____ Emergency Phone #: _____

Emergency Contact: _____ Relationship: _____

Landlord: Name & contact info: _____

When was your last physical examination? _____

Have you ever had any type of surgeries? _____

If so, please explain. _____

Why are you in to see us today? _____

Have you ever seen another doctor for this condition? _____

If so, who? _____

Thank you for your cooperation in getting all the necessary information to our staff, we will be with you momentarily!

Clouse Chiropractic Center
Patient History Form

What brings you to our office today? Circle choices: (neck pain) (mid back pain) (low back pain)

When did the problem start? _____

What caused your condition? _____

If you have pain, is it: (constant) (comes and goes)

Describe your pain: _____

What makes your pain worse? _____

What makes your pain better? _____

List any previous auto or work accidents and the year they happened: _____

Do you have any illnesses? (yes) (no) If so, what are they? _____

List any surgeries and they year they occurred: _____

Do you suffer from: (circle all that apply)

Headaches Urination Problems Allergies Dizziness Low Energy Level

Breathing Difficulty Digestive Problems Female Problems Excessive Thirst

Any appetite problems? (excessive) (poor)

Have you had a big weight gain in the last six months? (yes) (no)

Are you pregnant? (yes) (no)

List the date of your last menstrual period: _____

Employer's name and address: _____

List days of work lost due to condition: _____

If you are still working, are you working with pain? (yes) (no)

If yes, list job duties that produce pain: _____

What is your position with the company? _____

Do you smoke? (yes) (no) If so, how much per day? _____

Do you drink alcohol? (yes) (no) If so, how much per day? _____

What vitamins do you take? _____

Is your diet well balanced? (yes) (no) Do you eat: (fast food) (vegetarian)

Do you sleep well? (yes) (no) If not, why? _____

Any other important information about your health?

Family Physician: _____ Telephone: _____

Informed Consent to Chiropractic Treatment

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 hydrotherapy may also be needed.

Possible risk: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to 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 “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

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

- *Over the counter analgesics.* The risk of these medications include irritation to 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 include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

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 delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. 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.

Printed Name, Signature

Date

WITNESS:

Printed Name, Signature

Date



Clouse Chiropractic Center, Inc.

Assignment and Authorization

I, _____ hereby authorize and direct any insurance company and/or attorney to pay directly to you, *Clouse Chiropractic Center, Inc.*, all sums as may be due and owing to me for services rendered to me by reason of accident, to *Clouse Chiropractic Center Inc.* and withhold such sums from any benefits I may be entitled to as result of said accident. I hereby further give a lien to this office against and all insurance benefits and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by this office. This is an assignment of my rights and benefits to any sums payable to me by any insurance company to the extent of this office's services provided.

As consideration for this assignment, *Clouse Chiropractic Center Inc.* will forego demanding payment upon completion of each visit and will treat me without demanding payment until any insurance company has paid directly all sums due and owing or otherwise finally settled any claim I have for which the insurance company pays benefits. I understand that if I am not entitled to any sums paid by any insurance company or should all sums paid by all insurance companies total less than the amount of the services rendered, I will be personally liable for any amount still owed to *Clouse Chiropractic Center, Inc.* It is further understood that at any point, the monies received exceed my indebtedness, the excess balance will be returned to me by check from your office.

In the event any insurance company, obligated to make payments to me upon the charges made by the office for their services, refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my name or in the office's name and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjusted in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf.

Please be aware that our staff verifies your insurance information as a favor to you. The patient has all capabilities and should know their benefit information as they have a contract with the insurance carrier. When our office verifies your coverage, this does not guarantee payment from your insurance carrier. By signing this, you are fully aware of these conditions and understand in the default of payment, you, the patient, will be fully liable for all services rendered.

Date

Patient Signature

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are concerned with protecting your privacy. While the law requires us to give you this disclosure. Please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, that restriction is binding to us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name

Authorized Provider Representative

Signature

Date

Date

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (164.524)

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient signature

Authorized provider representative

Personal representative printed

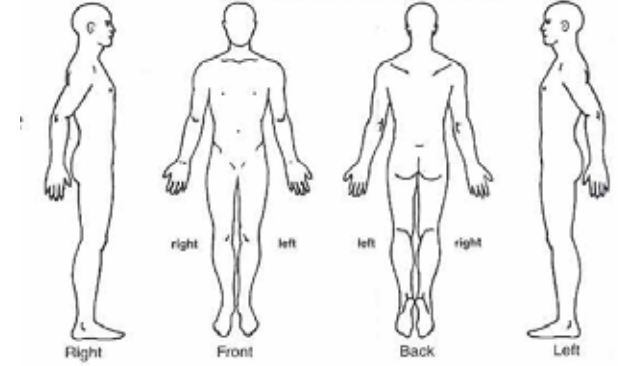
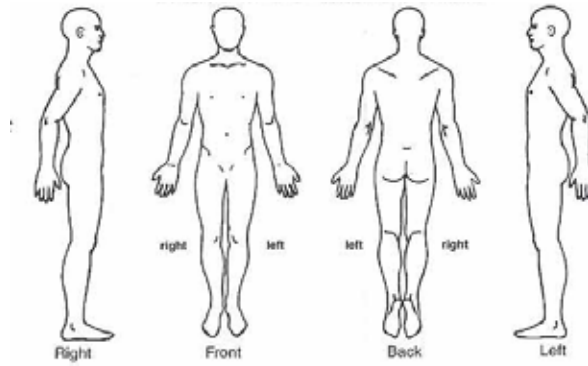
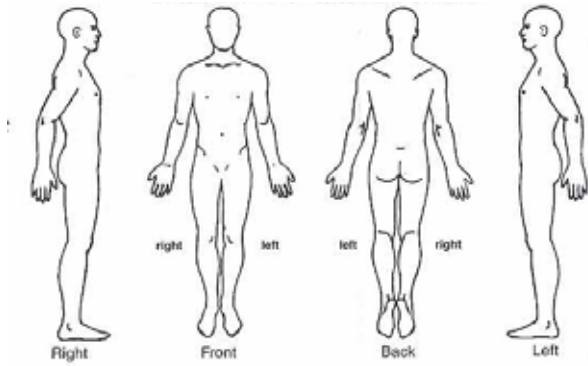
Personal representative signed

Description of personal representative's authority to act for the patient.

Mark areas of pain on figures below

Mark areas of pain on figures below

Mark areas of pain on figures below



Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

How does this problem effect your activities of daily living?

How does this problem effect your activities of daily living?

How does this problem effect your activities of daily living?

Sign: _____ Date: _____

Sign: _____ Date: _____

Sign: _____ Date: _____

Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Neck pain: 0 1 2 3 4 5 6 7 8 9 10
Mid-back pain: 0 1 2 3 4 5 6 7 8 9 10
Low back pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10

How does this problem effect your activities of daily living?

How does this problem effect your activities of daily living?

How does this problem effect your activities of daily living?

Sign: _____ Date: _____

Sign: _____ Date: _____

Sign: _____ Date: _____