# FAMILY CHIROPRACTIC & NATURAL HEALING CENTER

## PATHWAY TO HEALING AND HEALTH

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## Welcome

We look forward to your first visit with us. In order to provide a comprehensive holistic approach and address the root cause of your condition, please take a few minutes to complete the questionnaire on the next page. The quality of information you provide will facilitate in your evaluation and assist us in providing you the best customized personal program.

## Appointment Policy

Welcome to Family Chiropractic & Natural Healing Center. I am delighted to have you as a new patient and look forward to providing you with the highest quality care. In order to optimize our relationship, please take a minute to carefully read the appointment policy below.

My time and expertise is what you essentially pay for. To maximize your full scheduled treatment time it is essential to be on time for your appointments. However, occasionally life can present difficult scheduling challenges. If you expect to be more than 15 minutes late, please call to confirm availability. A 24 hour notice for cancelled or rescheduled appointments (Sunday excluded is required. This allows time to schedule another patient to be treated and the time is not lost. If we do not receive this 24 hr notice, your standard treatment fee may be charged. I have found that most patients respect my time as much as I respect theirs.

## Financial Policy

This office collects fees for services at the time of service. Cash, Checks, or Credit Cards (Visa, M/C, & AMEX) are all accepted. There is a $25.00 returned check fee for insufficient funds.

Patients who qualify for insurance billing will pay their deductible, co-pay, and/or co-insurance. All insurance information must be verified for their eligibility and benefits. Only the primary insurance will be billed.

## ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I and/or my dependents, have insurance and assign directly to Dr. Gregory A. Lind D.C. all benefits if any, payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all 'co pays' 'Co-Insurance', 'Deductibles', and any 'non-covered services' are payable at the time of each visit. The above named provider's office may use my health care information and may disclose such information to the above named insurance company)s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ **Private Pay/Cash:** By **checking** this box, I acknowledge that I DO NOT have insurance and understand that I am financially responsible for all services provided by Dr. Lind at the time they are rendered.

*Any questions I have concerning my appointments and financial policy have been answered. I have read this statement and fully understand it.*

**Signature:**_____ **Date:**_____

# PATIENT INFO/STATUS/AUTHORIZATION

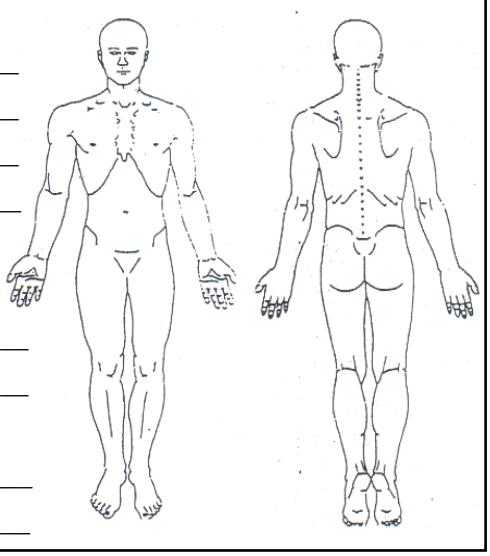
Office Use
File #: _____

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

Age: _____ DOB: _____/_____/_____ Gender: ☐M ☐F Status: ☐Married ☐Single ☐Widow ☐Divorced
Ages of Children: _____
Address: _____ City: _____ State:_____ Zip:_____
Cell Ph:_____ Home Ph:_____ E-Mail:_____
*(For Texting Purposes: Please Provide Cell Phone Service Provider: ex. ATT, Verizon….)*_____
Occupation:_____ Years Employed:_____ Employer's Name:_____
Spouse's Name:_____Emergency Contact:_____Phone No:_____
How or who referred you to this office?_____

**Please describe the condition that brings you to our office:**

_____
_____
_____



How did this occur?_____
Date it occurred:_____
Pain Level: Mild 0 1 2 3 4 5 6 7 8 9 10 severe
Have you had X-Rays, MRI or other test for this condition?_____
What treatment have you had for this condition?_____
Medications currently taking: OTC drugs, Vitamins, Herbs, or Homeopathic Remedies:
_____
Surgical Procedure: (List Dates) _____

**Please check any of the following that apply to you:**

☐Tobacco use ☐Alcohol use
☐Drug use
☐Coffee/ Tea/ Caffeinated Soft drinks (cups/day_____)
☐Stress Level: High Moderate Low
☐Exercise Days per Week: 0 1 2 3 4 5 6 7

Weight:_____Pounds
Height:___feet____inches

Time Spent exercising per event:_____

| | | | |
|---|---|---|---|
| ☐ Acid Reflux | ☐ Chronic Back Problems | ☐ Heart Problems | ☐ Neuropathy |
| ☐ Allergies | ☐ Chronic Headache | ☐ Hernia | ☐ Prostate Issues |
| ☐ Asthma | ☐ Chronic Fatigue | ☐ High B/P | ☐ Respiratory Issues |
| ☐ Bone Spurs | ☐ Concussion | ☐ High Anxiety | ☐ Rheumatoid Arthritis |
| ☐ Bulging Disc | ☐ Depression | ☐ Kidney Issues | ☐ Skin Issues |
| ☐ Bursitis | ☐ Diabetes | ☐ Liver Disease | ☐ Stenosis |
| ☐ Cancer | ☐ Digestive Issues | ☐ Lupus | ☐ Tendonitis |

I authorize Dr. Lind to Examine and Treat my condition as deemed appropriate through the use of Chiropractic Care, Homeopathic remedies, Traditional Chinese Medicine, and other natural healing methods.
Health and accident insurance policies are an arrangement between the insurance company and you. This office will prepare any necessary reports and forms to process your claim. Any charges not paid by insurance will be the patient's responsibility and payable at the time service is rendered. Please feel free to discuss with Dr. Lind, in complete confidence, all matters involving your physical and emotional health.

_____ _____
Patient Signature / Guardian's Signature Date

# I. HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and maybe used and disclosed and how you can access this information. Please review carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPAA" it is our legal duty to safeguard your Protected Health Information (PHI). Please note that we reserve the right to change the terms of the Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office. This Notice will remain in effect until it is replaced or amended.

During the course of our relationship with you, we will use and disclose PHI about you for treatment, payment, and healthcare operations. We gather personal information and health information from you, other healthcare providers, and third party payers. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside our practice. You may specifically authorize us to use PHI for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI.

**Marketing**
This office will not use or disclose your PHI for marketing communications without your written authorization. This office may send birthday cards, thank you cards, notice of clinic events, newsletters, and/or appointment reminders.

**Disclosure**
This office may use or disclose your PHI without your consent or authorization when required by law.

**Patient Rights**

1. Upon written request, you have the right to review and receive copies of your PHI
2. Upon written request, you have the right to receive a list of disclosures about your PHI.
3. You have the right to request additional restrictions on the use and disclosure of your PHI, permitted by law.
4. Upon written request, and as permitted by law, you have the right to request that we amend your PHI.
5. You have the right to receive all notices in writing.

If you have questions about this Notice or any complaints about our privacy, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W. Washington, D.C. 20201.

This Notice went into effect April 14, 2003.

**I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices.**

_____ _____
Date Print Name

_____
Signature

# INFORMED CONSENT

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

**The nature of the chiropractic adjustment**

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 hand 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. You may feel a sense of movement.

**Analysis / Examination / Treatment**

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

***Spinal manipulative therapy, various manual hands on techniques, neuro-motor re-patterning, stress release techniques, range of motion testing, muscle strength testing, ultrasound, radiographic studies, palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing.***

**The material risks inherent in chiropractic adjustment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications and their probabilities include but are not limited to: facture, disc injuries, dislocations, muscle strain, cervical muscle pain, rib/vertebra strains and separations, and burns. These are rare occurrences. 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. The scientific literature puts this risk at 1 in 1 million to 5 million which is **extremely rare**. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to identify any reason not to undergo this type of care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The availability and nature of other treatment options**

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 choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of those options and you may wish to discuss these with your primary medical physician.

**The risks and danger attendant to remaining untreated**

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.

**I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Lind and have had my questions answered to my satisfaction. 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.**

Dated: _____ Dated: _____

_____ _____

Print Patient's Name Doctor's Signature

_____

Signature of patient or Guardian (if a minor)

Dtd: 2018-05

# PATIENT SCREENING FOR COVID-19 QUESTIONAIRE

| | | |
|---|---|---|
| Have you had any TWO of the following within the last 14 days that you cannot attribute to another health condition? Fever (Temp above 100.3), Trouble Breathing, Shortness of Breath, Fatigue, Dry Cough, Altered Taste, Altered Smell, Muscle Aches, Sore Throat, (Circle those which apply) | YES | NO |
| Within the last 14 days, have you had close contact with someone who is CURRENTLY sick or confirmed COVID-19? | YES | NO |
| Have you traveled in the past 14 days to any regions affected by a severe outbreak of COVID-19? | YES | NO |
| Have you been involved in any large group functions in the last 14 days? | YES | NO |
| You agree to contact this office if you begin feeling any of the above symptoms within 14 days of your last office visit. | YES | NO |

_____

Signature of Patient