Rowe Family Chiropractic Center

Name _____ Date ____/____/____ Age____ Male/Female

Address _____ City _____State____ Zip _____

Phone: Primary_____ Secondary _____ Date of Birth____/____/_____

Email Address: _____

Height: _____ Weight:_____

Occupation _____ Employer's Name _____

Single/ Married/Divorced/ Widowed Spouse's Name _____

Number of children_____ Names, Ages & Gender _____

_____

Who may we thank for referring you? _____

Primary Care Physician's name_____

Location_____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according To severity	Rate of Severity 1= mild 10= unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

NECK PAIN	MID BACK PAIN	LOW BACK PAIN	HEART PROBLEMS
HEADACHES/MIGRAINES	SHOULDER PAIN	SCIATICA	THYROID PROBLEMS
DIZZINESS/VERTIGO	SCOLIOSIS	DISC PROBLEM	FIBROMYALGIA
TMJ	ASTHMA	RESTLESS LEGS	STOMACH PROBLEMS
SINUSES/ALLERGIES	FATIGUE	NUMB LEGS/FEET	LIVER/KIDNEY PROBLEM
NUMB ARMS/HANDS	SKIN CONDITIONS	PLANTAR FASCIITIS	INFERTILITY
ANXIETY/DEPRESSION	INSOMNIA	HIP/KNEE/ANKLE PAIN	BOWEL/BLADDER
ADD/ADHD/AUTISM	LOW IMMUNE SYSTEM	MENSTRUAL PROBLEMS	AUTOIMMUNE DISEASE

Other_____

CIRCLE ANY CONDITIONS YOU HAVE HAD OR HAVE CURRENTLY:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS _____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YES, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE EXPLAIN _____

OTHER TRAUMA/HOSPITALIZATION:

_____

IF THIS HEALTH PROFILE IS FOR A MINOR/ CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/ CHILD _____

I AUTHORIZE DR. NICHOLAS ROWE AND/OR DR. KERI ROWE AND ANY AND ALL ROWE FAMILY CHIROPRACTIC CENTER STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/ CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/ CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED/ ALTERED, I WILL IMMEDIATLEY NOTIFY ROWE FAMILY CHIROPRACTIC CENTER.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF ROWE FAMILY CHIROPRACTIC CENTER DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALTIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE. IT IS UNDERSTOOD AND AGREED THE AMOUNT PAID FOR X-RAYS, IS FOR EXAMINATION ONLY AND THE X-RAY NEGATIVES WILL REMAIN THE PROPERTY OF THIS OFFICE, BEING ON FILE WHERE THEY MAY BE SEEN AT ANY TIME WHILE A PATIENT OF THIS OFFICE. **BY SIGNING YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____

PRINT YOUR NAME HERE DATE

_____ _____

SIGNATURE YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT ROWE FAMILY CHIROPRACTIC CENTER.

_____ _____

SIGNATURE DATE

PATIENT INFORMATION

Contact in case of Emergency: _____ Phone # _____

NAME OF PRIMARY INSURANCE COMPANY: _____

Name of Insured_____ Insured Date of Birth_____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured _____Insured Date of Birth _____

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Nicholas Rowe, DC or Keri Rowe, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ Date _____

Dr. Rowe is not a contracted chiropractor with ASH; also Dr. Rowe is ineligible for reimbursement from ASH Group or Client for providing services to that member. By signing below you agree in advance to accept sole reasonability to pay for all services rendered. Any charges incurred for services rendered by any Contracted Ancillary Practitioner, Primary Care Physician or other contracted chiropractor, as a result of any referral Dr. Rowe may make for you will be ineligible for reimbursement by ASH group and/or the applicable Client.

Signed _____**Date** _____

Terms of Acceptance

In order to provide for the most effective environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing powers of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structure and configurations that interfere with normal nerve processing.
C. The chiropractic adjustment process involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in that we may work to maintain a supportive environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act or HIPPA. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and the follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I acknowledge that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS RISK IS MOST OFTEN MINIMAL, YET IN RARE CASES INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. SOME TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY FRACTURES.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTORS DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

_____ _____

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN DATE

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

PLEASE PRINT YOUR NAME HERE DATE

CONDITION	SPOUSE	DAUGHTER	SON	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					