Elkridge Chiropractic
6010-K Meadowridge Center Dr
Elkridge, MD 21075
410-379-8300

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize the Elkridge Chiropractic Center and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Elkridge Chiropractic doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

The specifics of the doctor's recommendation will be further explained following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, the Elkridge Chiropractic doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained my insurance benefits / costs.

To aid the understanding of my condition and the reasons for the proposed course of care, Elkridge Chiropractic has provided me with information and the Elkridge Chiropractic doctors have answered my questions regarding the planned treatments and course of care that I will receive. The doctors of the Elkridge Chiropractic have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to,

fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

Doctor's Notes:

_____ _____
Signature of Doctor Date

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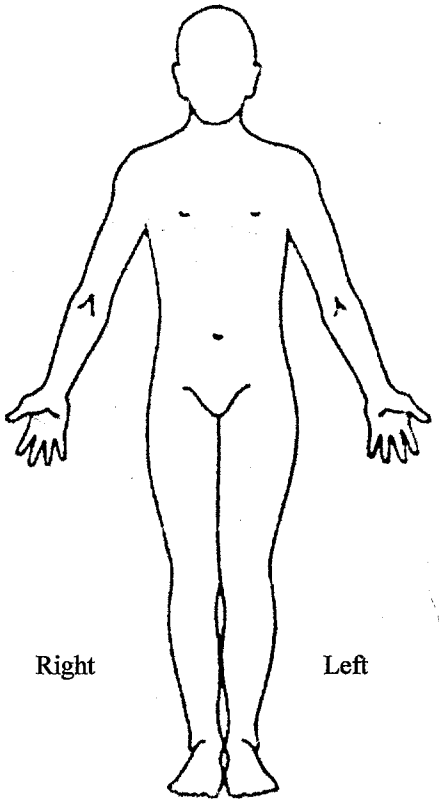
Visual Analog Scale

Elkridge Chiropractic & Physical Therapy

SHOW AREAS OF PAIN OR UNUSUAL FEELING

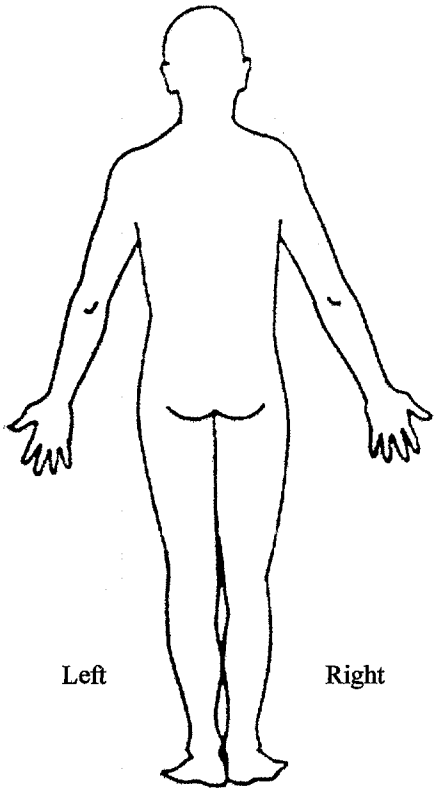
Mark the areas of the body where you feel the described sensation(s) listed below OR
WRITE IN YOUR OWN. Draw arrows from the words to the area(s) of discomfort



Constant
Comes & Goes
Burning
Stabbing
Achy
Sharp
Dull
Tingling
Numbness
Stiffness

_____

_____

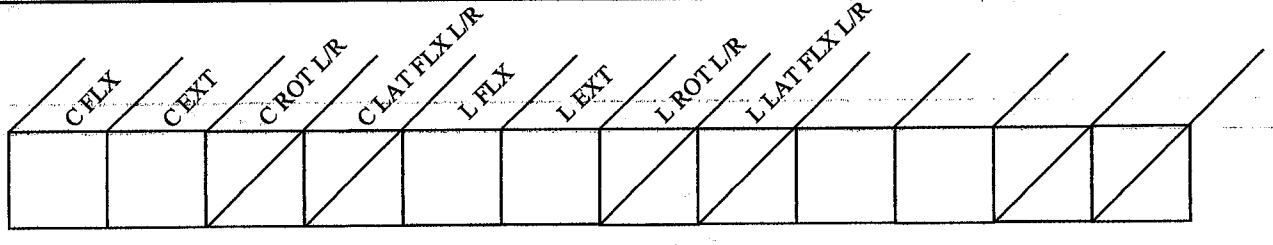


(Rate your CHIEF COMPLAINT ONLY on the scale below. 0= NO PAIN 10 = EXTREME pain)

Pain Scale (please Circle) 0 /1/ /2/ /3/ /4/ /5/ /6/ /7/ /8/ /9/ /10/

Print Name Here _____

Patient Signature _____ Date ____/____/_____



Doctor: _____ Date _____

one

WELCOME

Elkridge Chiropractic
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ABOUT YOU

Today's Date: ___/___/___ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: Carrier _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have kids? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ___/___/___

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

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PLEASE CONTINUE ON BACK

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IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? ____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Nursing? ❑ Yes ❑ No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ❑ CASH ❑ Check

_____ /____

❑ Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

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Suite K
Elkridge, MD 21075

Patient Authorization to Use and Disclose Protected Health Information (PHI)

I hereby authorize Elkridge Chiropractic Center to use and disclose my Protected Health Information ("PHI") according to the rules of the Health Insurance Portability and Accountability
Act ("HIPAA").

Name of Individual (Printed)_____

Signature of Individual_____ Date_____

Witness:_____

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I acknowledge that I have been informed of the Notice of Privacy Practices of Elkridge Chiropractic Center, that it is in the waiting room for me to read, and that I may request to have
a written copy.

_____ Yes, I do request a written copy of Elkridge Chiropractic Center's Notice of Privacy Practices.

_____ No, I do not request a written copy of Elkridge Chiropractic Center's Notice of Privacy Practices.

Name of Individual (Printed)_____

Signature of Individual_____ Date_____

Witness:_____

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MISSED APPOINTMENTS

I understand that Elkridge Chiropractic Center has the right to charge a $50 missed appointment fee for appointments not cancelled in advance. The fee is charged as the appointment slot will not be able to be filled for patients who are in need of care.

Patient Signature_____ Date_____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize _____ Insurance Company to pay by check, made out to ELKRIDGE CHIROPRACTIC CENTER, the medical expense benefits allowable and otherwise payable to me under my insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

Patient Signature_____ Date_____

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ELKRIDGE CHIROPRACTIC CENTER
FINANCIAL POLICY

HEALTH INSURANCE POLICY

EXPLANATION OF BENEFITS

Most insurance companies have benefits for chiropractic treatment. The yearly deductible, copay and percent covered will vary with each insurance company.

OFFICE POLICY

- You must provide us with a copy of your insurance card and picture ID. If your insurance changes, you must provide us with a copy of your insurance card.
- We will call and verify your insurance coverage by your second visit. We will discuss with you what your copay, deductible, and/or limitations are per your insurance. (Verification of benefits in not a guarantee that the insurance will pay what has been stated)
- Co-payment are due at the time of service. Deductible are required within 30 days of the first visit. Any Services denied by your insurance will be billed to you.
- If you receive payment form your insurance company for service rendered in our office, you must bring the check and any attached statements to our office immediately. You will not be permitted to make "payment" on an insurance check. Your account will be turned over to a collection agency in that case and an additional fee will be charged.
- The balance of you account is ultimately your responsibility. We accept payment in the form of CASH, CHECK, VISA or MASTERCARD.
- If you receive a bill, payment is due upon receipt. If your account should remain unpaid for 90 days, it will be turned over to a collection agency and additional fee will be charged.

CO-INSURANCE

Is a percentage of the total cost for each visit.

COPAY

Is a fixed amount per your insurance that you pay per visit.

DEDUCTIBILE

The amount you pay for covered healthcare services before your insurance plan starts to pay.

I HAVE READ, UNDERSTAND AND ACCEPT THESE POLICIES.

SIGNATURE_____ **DATE**_____