King Chiropractic Patient Intake and Consent Form					
First Name:		Last Name:		MI:	Date:
DOB:	Age:	Sex:	Email:		
Address:			City:	State:	Zip:
Phone:			Emergency Contact:		
Emergency Contact Phone:			Relationship to Patient:		

Welcome to King Chiropractic

When a person seeks the services of a chiropractor, it is essential that they fully understand the objectives of that particular chiropractor.

We have one goal at King Chiropractic, to restore and maintain the integrity of the spinal cord and its nerve roots. The spinal cord and its spinal nerves are vital pathways protected by the bones of the spine (vertebrae). Misalignments of these vertebrae cause nerve interference, called vertebral subluxations. Subluxations are caused by many of the things you do every day and keep your whole body from functioning properly. It is our absolute conviction that the body is always better off without this interference.

Consequently, the objective of King Chiropractic is to provide a chiropractic adjustment to correct subluxation and restore nerve function. It is not the objective or intention of King Chiropractic to fix, treat or attempt to cure any physical, mental or emotional ailments or to give any advice about any ailments. With a proper nerve supply your whole body is better able to reach its full potential and to express more life.

The information we receive from you is important. We ask only that which is necessary for your care here at King Chiropractic. Please fill out the forms completely and to the best of your ability. If you have any questions or if there is any information you feel we should know, please mention it to the chiropractor.

I, ___________________________________, have read the above, understood it fully and choose to receive chiropractic as it is defined and explained here.

Who referred you to King Chiropractic? ____

Signature: ______________________________________ Date: _____________________

Case History

1.What is your major health concern? ____

____

____

2. If this is a recurrence, when was the first time you noticed this problem?____________________
   How did it originally occur?____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? ____

   ____

3. Is there any radiating pain? If so, where? ____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ____
   How long does it last? All Day _________ Few Hours ___________ Other ________________
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: ____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________

   ____

6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other ____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _______

   ____

   If no, what have you tried to do that has not helped? ____________________________________

   ____

8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____
   Lifting _____ Twisting _____ Other ____

   ____

9. List any major accidents you have had other than those that might be mentioned above: _______

   ____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: ____

    ____

    ____

NO SYMPTOMS ____ EXTREME SYMPTOMS

Please place an “X” on the line above to indicate level of problem.

Doctor’s Signature ____ Date _____________

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

Patient Health Information and Privacy policy: This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has a right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Notice Specifically Regarding Children

When I bring my children into this office to receive care, I am giving written permission for Dr. Rhett King to make the best decisions regarding the chiropractic care of my child/children since I, the parent/legal guardian listed below may not be present at all of his/her schedule visits. I understand that I or another parent/legal guardian must be present for my child's first appointment. I also understand the signed consent will be valid until the minor child is 18 years of age or unless I withdraw this permission in writing.

Signature Authorizations

I, the undersigned, authorize Dr. Rhett King to provide chiropractic care to me and/or my minor dependent(s).

Financial Responsibility and Authorization for Payment

I understand that I am financially responsible for payment for services rendered by King Chiropractic. I authorize King Chiropractic to provide chiropractic care to me. In the case of Medicare and other third party payers, I understand that this office does not accept assignment and agree to pay at time of service.

Regarding receipt of this offices HIPAA document

I also acknowledge that I have read and understand this offices HIPAA policy document and was offered a copy of it. I realize that I may elect not to keep a copy of it. I had test to the fact that all the information provided on this form is accurate and truthful and that I have read and understand all the stated policies noted in this document.

The doctor and I have adequately discussed the risks involved with treatment that are specific to my condition and other treatment options. I have also provided the above information freely and accurately. I present myself today for no other reason than an evaluation and treatment.

Patient Signature: ______________________________ **Date:**______________

Guardian Signature: ______________________________ **Date:**______________

Doctor Signature: ______________________________ **Date:**______________

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

Tha patient certifies that all information provided to the office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. In doing so, the patient understands, acknowledges and affirms that such services may involve bodily contact, touching and/or direct contact of a sensitive nature. The patient may refuse treatment at any time.

Treatment of minors: If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on premises during any such treatment and waive any claim I may have resulting from failure to do so.

Liability: I know and agree that King Chiropractic is not responsible for loss or damage to personal valuables.

Waiver and Release: I hereby release, discharge and acquit King Chiropractic, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician physician or urgent care services.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ______________________________ **Date:**________________

Guardian Signature: ______________________________ **Date:**________________

Doctor Signature: ______________________________ **Date:**________________