ADVANTAGE
SPINAL DYNAMICS

Confidential Patient Information

First Name _____ Nick Name _____ Date _____

Last Name _____ Middle Name _____

Address _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

Home Phone # (____)_____ Cell # (____)_____ Work # (____)_____

Email _____

Contact Method (check one) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Personal Email

☐ **I wish to receive text message reminders for my appointments. My cell service carrier is _____.**

☐ **I wish to receive email message reminders for my appointments.**

D.O.B. (mo/day/yr) _____/_____/_____ Age _____ Gender (check one) ☐ Male ☐ Female ☐ Unspecified

Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____

Social Security # _____ -_____ - _____ Employer _____ Address _____

Employment Status (check one) ☐ Employed ☐ FT Student ☐ PT Student ☐ Other ☐ Retired ☐ Self Employed

Emergency Contact _____ Phone # (____)_____

Medical History (if any of the following are relevant to your medical history, please check the accompanying box)

☐ Allergies	☐ Concussion	☐ Heart Trouble	☐ Numbness
List: _____	☐ Convulsions	☐ Hepatitis	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Digestive Disorders	☐ Multiple Sclerosis	☐ Scarlet Fever
☐ Backaches	☐ Dizziness	☐ Muscular Dystrophy	☐ Sinus Trouble
☐ Cancer	☐ Epilepsy	☐ Nervousness	☐ Tuberculosis

How did you find out about our office/who referred you to us? _____

☐ Friend/Family ☐ Doctor ☐ TV ☐ Internet ☐ Sign ☐ Phonebook ☐ Home Mailer ☐ Newspaper (please give ad to front desk)

Is your visit due to an accident? ☐ No ☐ Yes (if yes, please see receptionist for an injury report.)

Current medications, including dosage. If there are no medications check here: ☐

1) _____ 5)_____

2) _____ 6) _____

3) _____ 7) _____

Have you seen a chiropractor before? ☐No ☐Yes Last visit_____

Describe the purpose of this visit: _____

_____

_____

How did your symptoms start? _____

_____

_____

List any known allergies you have had to any medications. If no allergies are known, check here: ☐

1) _____ 2) _____

Describe any operations you've had (and dates): _____

_____

Do you have insurance? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Advantage Walk-In Chiropractic extends credit to me, and I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I understand that if my account is 60 days past due an $5 late fee will be assessed per billing cycle and any accounts 120 days past due will be forwarded to our collections department and will be subject to collection-processing fees. If my check is dishonored I understand that a $25 processing fee will be assessed to my account. I hereby authorize the doctors at Advantage Walk-In Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive payment and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions. But if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature_____ Date_____

Restrictions:

INFORMED CONSENT FOR EXAMINATION & TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic (**Dr. Jamie Ricks)** and/or his/her preceptor and/or other licensed doctors of chiropractic 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 including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information relayed by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, Spinal Dynamics Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided. I understand that Spinal Dynamics Chiropractic reserves the right to change their information, policies and practices, and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Spinal Dynamics Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent for Chiropractic Adjustments and Care. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (Printed)	Date
Patient Signature: (Legal Representative, Attorney, Guardian, Parent)	Date
Doctor of Chiropractic Signature	Date