

<i>Davis Chiropractic</i>			
Confidential Information			
		Patient	Guarantor
First Name ----->			
Middle			
Last Name			
Address			
City			
State			
Zip			
Home Phone			
Cell Phone			
E-mail Address			
Birth Date/Age			
Sex		M F	
Marital Status		M S W D	
Social Security #			
Referred By:			
Employer			
Occupation			
Address			
City			
State/Zip			
Work Phone			
Spouse's Name			
Spouse's Occupation			
Nearest Relative			
Relative's Phone			
ARE YOU INSURED FOR CHIROPRACTIC CARE?			
	Primary	Secondary	
Company			
Policy Number			
Policy Holder			
Relationship			
Birth Date			
Social Security #			
<p>I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Matthew J. Davis, DC 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 Matthew J. Davis, DC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.</p>			
Patient's Signature		Date	
Guardian Authorizing Care		Date	
Information Taken By		Date	

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness
Symbol → NNNN

Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS

○ Circle any area of pain not represented by a symbol.

Example

Right

Front

Back

Left

What is your Primary Complaint?	
When did it begin?	
Describe where it is?	
Where does it travel?	
What is the intensity?	0 1 2 3 4 5 6 7 8 9 10 (severe)
How often do you have it?	Constant or _____ days per week/mo
How long does an episode last?	Constant or _____ minutes/days
What makes it better or worse?	
What have you done to try to help your complaint:	

What is your Second Complaint?	
When did it begin?	
Describe where it is?	
Where does it travel?	
What is the intensity?	0 1 2 3 4 5 6 7 8 9 10 (severe)
How often do you have it?	Constant or _____ days per week/mo
How long does an episode last?	Constant or _____ minutes/days
What makes it better or worse?	
What have you done to try to help your complaint:	

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

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 complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

I hereby authorize Dr. Matthew J. Davis and whomever he may designate as his assistants to administer care as he so deems necessary to my son/daughter.
Dated at Omaha, NE, _____, 2010.

_____ Signed

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Davis has my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____.

(signature)

(date)

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date