ROWE
CHIROPRACTIC
OFFICES

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Date: _____

PATIENT APPLICATION SURVEY

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Ph: (_____) _____

City, State, Zip: _____ Cell Ph: (_____) _____

E-Mail: _____@_____ Work Ph: (_____) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse Name: _____ Work(_____) _____ Cell: (_____) _____

Names of Children: _____ Ages: _____

Language Spoken: _____ Race: _____ Ethnicity: _____

How did you hear about us? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? YES NO Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? **YES** **NO**

Did you know your posture determines your health? **YES** **NO**

Are you aware of any of your poor posture habits? **YES** **NO**

Explain Answer: _____

Are you aware of any poor posture habits in your spouse or children? **YES** **NO**

Explain Answer: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told of felt like you carry your head forward, noticed a rounding o your shoulders or a developing “hump” at the base of your neck? **YES** **NO**

PURPOST OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? YES NO If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin: _____ / _____ / _____ When did you first notice it? _____

Is this condition getting worse? YES NO Is this condition: __Constant __ Comes & Goes __ Activity Related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? YES NO Describe: _____

Have you experienced this condition before? YES NO If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

ADDITIONAL REASONS FOR THIS VISIT, IF APPLICABLE:

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? YES NO If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin: _____ / _____ / _____ When did you first notice it? _____

Is this condition getting worse? YES NO Is this condition: __Constant __ Comes & Goes __ Activity Related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? YES NO Describe: _____

Have you experienced this condition before? YES NO If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

HEALTH LIFESTYLE

Do you exercise? YES NO How often / weekly? 1X 2X 3X 4X 5X other:_____

Do you smoke? YES NO How much? _____

Do you drink alcohol? YES NO How much / week? _____

Do you drink coffee? YES NO How many cups / day? _____ Amount milk / sugar? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTHCONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When those vertebrae are twisted from their normal position, they ill cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any and all health condition(s) you may be experiencing, now or in the past.

CERVICAL SPINE (NECK): Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands, and head affecting these parts of your body. Do you experience. . .?

□ Neck Pain □ Headaches □ Sinusitis □ Dizziness
□ Pain in shoulders/arms/hands □ Allergies/Hay Fever □ Numbness tingling arms/hands □ Recurrent colds/flue
□ Visual disturbances □ Hearing disturbances □ Coldness in hands □ Low Energy/Fatigue
□ Weakness in grip □ Thyroid conditions □ TMJ/Pain/Clicking

Explain: _____

THORACIC SPINE (UPPER BACK): Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience. . .?

□Heart Palpitations □ Recurrent Lung Infections/Bronchitis □ Heart Murmurs □ Heart Attacks /Angina
□ Asthma/Wheezing □ Pain on Deep Inspiration/Expliration □ Shortness of Breath □ Tachycardia

Explain: _____

THOPRACIC SPINE (MID BACK): Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves to your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience. . .?

□ Mid Back Pain □Nausea □ Pain Into Your Ribs/Chest □ Ulcers/Gastritis
□ Indigestion/Heartburn □Tired/Irritable after eating or hungry □ Hypoglycemia □ Reflux

Explain: _____

LUMBAR SPINE (LOW BACK): Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience. . .?

□ Pain in your hips/legs/feet □ Weakness/injuries in your hips/knees/ankles □ Low Back Pain □ Frequent/difficult urine
□ Numbness/tingling in legs/feet □ Recurrent bladder infections □ Sexual Dysfunction □ Constipation/Diarrhea
□ Muscle cramps in legs/feet □ Coldness in legs/feet □ Menstrual irregularities/cramping (females)

Please list any health conditions not mentioned: _____

_____

Please list any medications/surgeries: _____

_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services □ **YES** □ **NO**

Patients Signature _____ Date _____

Guardian/Spouse's Signature Authorizing Care _____ Date _____
I hereby authorize Rowe Chiropractic Offices to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____ Policy # _____

Address _____ Phone # (_____) _____

Insured's Name _____ Insured SS #: _____

Relationship to Insured _____ Birthdate: _____ / _____ / _____

Employer: _____

Who should receive charges on your account?

PATIENT **SPOUSE** **PARENT/GUARDIAN** **WORKERS COMP**

AUTO INSURANCE **MEDIARE** **PERSONAL HEALTH INSURANCE**

RADIOGRAPH CONSENT

I _____ do hereby give my consent to allow Rowe Chiropractic Offices and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant. _____ (Innitial)

Signature of Patient or Guardian of said Minor _____ Date_____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

□ Diabetes
□ Rheumatic fever
□ High blood pressure
□ Kidney Disease
□ Liver Disease
□ Broken bones/fractures
□ Pneumonia
□Whooping Cough
□ Thyroid
□ Arthritis
□ Varicose veins
□ Circulatory problems
□ Heart Disease
□ Epilepsy/seizures
□ Metal Implants
□ Appendectomy
□ Polio
□ Chicken Pox
□ Small Pox
□ Lumbago
□ Neurological problems
□ Stroke
□ Cancer
□ Migraine Headaches
□ Infectious disease
□ Tonsillectomy
□ Tuberculosis
□ Mumps
□ Influenza
□ Pleurisy
□ Lung Disease
□ Heart murmur
□ Osteoporosis
□ Arthritis
□ Gall Bladder
□ Hernia
□ Anemia
□ Measles
□ Eczema
□ Other: _____

AUTHORIZATION CARE

I authorize and agree to allow the doctor to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

_____ _____ _____ _____
Patient's Name Printed Date Patient's Signature Date

_____ _____ _____
Minors Name Guardian/Spouse's Signature of Authorizing care for minor Date

IN CASE OF EMERGENCY

NAME: _____

RELATIONSHIP: _____

WORK PH: _____

HOME PH: _____

CELL PH: _____

FORMS OF PAYMENTS:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.

I understand that I am responsible for my contracted payment at the time of service. 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. I will be responsible for any costs of collection, attorney's fee or court cousts required to collect my bill. We accept cash, personal checks, VISA, MasterCard, American Express, and DISCOVER. Any counced checks and fee's will be my responsibility and will be paid full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

_____Initial

HIPAA GUIDELINES

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your PHI to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment. We may have to disclose you health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

_____Innitial

YOUR RIGHTS

You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding upon us. You may revoke your consent to us at any time; however, your revocation must be in your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims.

I have read your consent policy and agree to it's terms. I am also acknowledging that I have received a copy of notice if requested.

_____ _____ _____

Sign Name Date Provider Representative

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES ROWE CHIROPRACTIC OFFICES TO USE AND/OR DISCLOSE PROTETED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZTIONS:

I give permission to Rowe Chiropractic Offices to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, health related e-mails, messages & information about treatment alternatives, or other health relation information as well as any advertisements, newsletters, or patient of the week/month postings.

I give permission to Rowe Chiropractic Offices to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Rowe Chiropractic Offices permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I, _____, understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges: *The right to review the notice prior to signing this consent

*The right to object to the use of my health care information for directory purpose
*The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Name: _____

Signature: _____

Date: _____