Welcome to Our Office

Welcome to Zahn Chiropractic. We are happy to have you here today. If you have any questions concerning our policies, forms, or procedures, just ask.

Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed as well as how you may have access to the information.

We may share your health information to:

· Treat you · Collect payment · Run our office
· Thank you for referring other patients · Inform you of other services

We may use your information for:

· Health and safety reasons · Reporting to law officials · Court hearings and filings
· Reporting to workings compensation · Reporting victims of abuse

You have the right to:

· Request confidential communications · Ask us to limit information sharing · Request a copy of your health record · Amend your protected health information

· Request a list of whom we share your health information with · Advise us if you believe your privacy rights have been violated

Consultation and Exam

During today's visit, you will be asked to complete some confidential health information which we will then discuss with you during the consultation. We will then perform an exam to better assess your condition.

If we believe we will be able to help you, you will receive a report of findings and recommendations for treatment. During the course of your treatment, periodic progress evaluations will be performed to measure your improvement.

I have received a copy of a Notice of Privacy Practices for Zahn Chiropractic. _____
Patient Initials

I understand and agree to the above information.

_____ _____ _____
Patient or Guardian Name **Patient or Guardian Signature** **Date**

Financial Policy

Zahn Chiropractic is currently a provider in a number of insurance plans, and as such all co-insurances, co-pays, or deductible payments are due at the time of service. Fees for any non-covered services or denied services remain your responsibility, and any disputes must be made between you and your insurance carrier. If your insurance provides out-of-network benefits, we will bill the insurance for you and you may receive a refund for a portion of the submitted fees, but we do not guarantee reimbursement.

By signing below, you acknowledge that you have reviewed the financial policy at Zahn Chiropractic and are aware that **all fees are due at the time of service** unless prior arrangements have been made. You hereby authorize Zahn Chiropractic to accept assignment of your insurance benefits and bill insurance for services rendered to you. You authorize the release of any information pertinent to your case to any insurance company, adjustor, or attorney to facilitate the collection under this assignment. You acknowledge that you are responsible for any co-pays, co-insurances, or deductibles as well as any amount denied by your insurance company or for non-covered services. You authorize payment of charges to be made directly to the doctor(s) of Zahn Chiropractic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy.

2. Amounts owed on my behalf from proceeds of any settlement related to my case.

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Guardian Name (if a minor)	**Signature**	**Date**

Informed Consent

The nature of the chiropractic adjustment and other treatments.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The Doctor will use that procedure to treat you. The Doctor may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As a part of the analysis, examination, and treatment, you are consenting to the following procedures: soft tissue mobilization/release, palpation, vital signs, range of motion, orthopedic, neurological, and postural analysis testing, hot/cold therapy, EMS, and cold laser therapy.

The material risks and probability of those risks occurring.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. While very rare, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke or vertebral artery dissection. The most common side effect is stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Other treatment options and risks of remaining untreated.

Other treatment options for your condition may include rest, medications, hospitalization, or surgery, all which carry their own risks which you may wish to discuss with your primary medical physician. Should you choose to remain untreated, the formation of adhesions further reducing mobility, neurological loss, and continued degeneration may occur, complicating future treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____

Patient Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

Patient Initial Intake

First Name			Last Name			MI
Date of Birth			Married Single Other		Male Female Other	
Address				City		
State	Zip	Phone		Email		
Employer		Occupation		Work Phone		
Insurance Name		Subscriber ID		Group Number		
Emergency Contact Name/Phone						
How did you hear about us?						

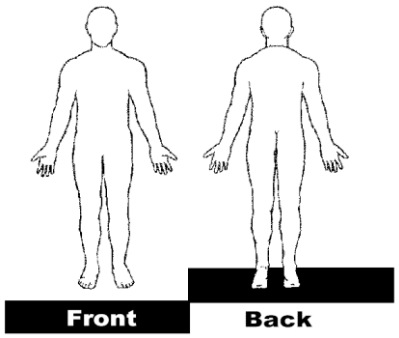
CURRENT COMPLAINT AND HOW IT BEGAN

_____

_____

Began on: _____

Related to: ☐ Work ☐ Auto Accident ☐ Other Accident



Rate Your Complaint Today:

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Social History (Number Per Week)

Exercise	Alcohol	Tobacco	Caffeine	Soda

History Of:

Recent Fever	☐	Heart Attack	☐	Diarrhea	☐
High Blood Pressure	☐	Aneurysm	☐	Abdominal Pain	☐
Stroke	☐	Angina	☐	Liver/Gall Issue	☐
Diabetes	☐	Bleeding Disorder	☐	Nausea/Heartburn	☐
Broken Bone	☐	Asthma	☐	Loss Bowel Control	☐
Bone Density Loss	☐	Vision Trouble	☐	Prostate Problems	☐
Infection	☐	Vertigo/Dizziness	☐	High Cholesterol	☐
Tumors/Cancer	☐	Kidney Infection	☐	AIDS/HIV	☐
Numbness	☐	Loss Bladder Control	☐	Latex	☐
Slurred Speech	☐	Urgency/Leakage	☐	Other	_____

Family History: ☐ Cancer ☐ Diabetes ☐ Stroke/TIA ☐ Heart Disease

Medications
Surgeries
Hospitalizations

_____ _____ _____

Patient Name **Patient or Guardian Signature** **Date**

Revised 1/2019