



**SHAFFER
CHIROPRACTIC
CENTER**
Scott M. Shaffer, B.S., D.C.

PATIENT INFORMATION FORM (Please Print)

PATIENT NAME _____ DATE _____

STREET ADDRESS _____

MAILING ADDRESS (If different than Street Address) _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ WOULD YOU LIKE TEXT ALERTS _____

AGE _____ DATE OF BIRTH _____ E-MAIL _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ OCCUPATION _____

SPOUSE/PARENT/GUARDIAN NAME _____

EMPLOYER _____ WORK PHONE _____

MEDICAL DOCTOR _____ LAST VISIT _____

In case of emergency, whom should be notified _____ PHONE _____

Whom may we thank for referring you _____

Who is financially responsible for this bill _____

Patient will be paying today by _____ CASH _____ CHECK _____ Visa/ MC

If applicable, this case may be turned over to _____ Personal Injury/Auto Accident _____ Ins.

- "I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.
- "I hereby release and allow SHAFFER CHIROPRACTIC CENTER to examine and treat the above-named minor as I am the parent/guardian."
- "If applicable, I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I am financially responsible for non-covered services."

SIGNED _____ DATE _____

"I have read and agree to the above statements as I am patient and/or parent/guardian."



SHAFFER CHIROPRACTIC CENTER

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient ID #: _____

I hereby acknowledge that I have received a copy of Shaffer Chiropractic Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- Parent or guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of decedent's estate
- Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)



**SHAFFER
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**INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP FOR CHIROPRACTIC CARE
CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment and mobility allow nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustment, or health care, if he is aware that such may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

Signature of patient or parent/guardian

Date



FINANCIAL AGREEMENT AND OFFICE POLICIES

Page 1 of 2 (Sign on Page 2)

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide:

PROCEDURE	PURPOSE	WHEN PERFORMED	FEE
Consultation	Discuss your health problems and review your case history.	First visit, new injuries, or new condition.	N/C
Evaluation/ Management (Examinations)	Ascertain the nature and severity of your health problems. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, exacerbations, and progress examinations.	\$ 60.00- \$110.00.
Chiropractic Manipulative Treatments (Adjustments)	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problems.	As indicated by examination or evaluation.	\$ 40.00- \$ 75.00.
Therapy (Ice Packs)	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.	\$ 5.00- \$ 10.00.
Cervical Contour Pillows	Help maintain upper body stability and increase sleep.	As indicated by examination or evaluation.	\$120.00- \$190.00
Arch Support Orthotics	Help maintain lower body stability and strength.	As indicated by examination or evaluation.	\$200.00- \$350.00.
Nutritional/ Dietary Screenings	Help balancing nutritional needs.	As indicated by examination or evaluation.	\$ 75.00- \$ 100.00.

FORMS OF PAYMENT

Patients are responsible for full payment at the time of service. We accept cash, personal checks, and Visa/MC. Any credit arrangements must be authorized in advance. (See Page 2)

Time of service, self-pay discounts are available. Ask the front desk.



FINANCIAL AGREEMENT AND OFFICE POLICIES Page 2

INSURANCE/CONTRACT SERVICES/THIRD PARTY

Other options are available if your Chiropractic Care is covered by Health Insurance, Medicare or Personal Injury. Please note, we no longer participate in Medicaid and Workers Compensation claims. All professional services are rendered and charged to the patient receiving care and **not** to an insurance provider. **You are ultimately responsible for all charges received.** As a courtesy, we will submit statements, and reports to any involved Third Party, however this will be done only for Primary insurance providers, and not for Secondary insurance providers. We will not become involved in disputes with insurance companies regarding deductibles, co-payments, covered charges, non-covered charges, secondary insurance, "usual and customary" charges, "medical necessity" reports, and prior authorization reports, other than to supply information. This Office and the Doctor make no claim as to whether we are a Participating In Network Provider in your Health Insurance network. Ice Packs, Cervical Contour Pillows, Arch Support Orthotics, and Nutritional/ Dietary screenings will **not** be billed to Third Party payers unless otherwise approved by the front desk.

We will accept assignment in the following cases; (Approval must be sought through the front desk or the Doctor). 100% on **approved** personal injury/ automobile accidents. The insurance co-payment on **approved** Health Insurance and Medicare cases once it is determined what that amount is. **Otherwise, you are responsible for paying for any co-payments/deductibles at the point services are rendered.**

SPECIAL ARRANGEMENTS AND OVERDUE ACCOUNTS

We will not deny the benefits of Chiropractic Care due to their inability to pay our published fees. If financial hardship necessitates an Individual Consideration Contract, payment will be handled as stated...

Any outstanding balances are billed monthly and may be considered past due 30 days after the invoice date or when special arrangements are not met. Balances older than 30 days may accrue charges of \$15.00 per month, plus any legal or collection fees or returned check fees, which is \$50.00.

Patient Agreement

I have read, understand, and agree to this Financial Agreement and Office Policies (2 Pages)

Patient/Responsible Party (Please Print and Sign)

Date

Office Representative



SHAFFER CHIROPRACTIC CENTER

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SUBJECTIVE COMPLAINTS Page 1 of 2 (Sign on Page 2)

Explain **WHEN** and **HOW** it happened: _____

Complaints/Symptoms: Come and go Came on gradually Came on suddenly VAS Score ____ / 10

Symptoms have persisted for: Hours 1 Day Days Weeks Months Years

Symptoms developed from: A work-related injury Auto accident/personal injury Other

Describe complaints (please give details):

Involving Neck & Head: _____

Involving Mid-back / Shoulders / Arms & Hands: _____

Involving Low back / Hips / Legs & Feet: _____

What activities make condition WORSE? _____

What activities make condition BETTER? _____

Have you ever had this condition before? Yes No

If yes, when? _____

Give name of doctors previous seen for this present condition: _____

What MEDICATIONS are you presently taking? For what conditions? _____

Symptoms are **BETTER** in: AM Midday PM Symptoms are **WORSE** in: AM Midday PM No change with time of day.

Indicate ability to perform the following activities.

Use these codes: U = Unable P = Painful D = Difficult L = Limited N = Normal

- | | | |
|---|--|--|
| <input type="checkbox"/> Getting in and out of car | <input type="checkbox"/> Bending over forward | <input type="checkbox"/> Lying on back |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Sitting at a table |
| <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Turning over in bed |
| <input type="checkbox"/> Bending forward to brush teeth | <input type="checkbox"/> Standing for more than 1 hour | |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Balancing |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Reaching |
| | | <input type="checkbox"/> Dressing self |
| | | <input type="checkbox"/> Sleeping |
| | | <input type="checkbox"/> Gripping |

Habits:

- Hours of sleep _____
- Coffee/Tea _____
- Alcohol _____
- Tobacco _____
- Exercise _____
- Hobbies _____

Check symptoms of nervous stress: Y = Yes N = Leave blank

- | | | | | |
|--|---|---|---|------------------------------------|
| <input type="checkbox"/> Blurring vision | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low resistance | <input type="checkbox"/> Numbness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Buzzing/ringing in ears | <input type="checkbox"/> Depression/crying spells | | | |
- Headaches - How often do you have headaches? _____

Have you had any of the following?: Y = Yes N = Leave blank

- | | | | | | |
|---|---------------------------------------|------------------------------------|--|---|---------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Mental disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Polio | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Whooping cough | |

Operations / Spinal procedures: (Please list) _____

Previous accidents, falls, unconsciousness: (Please describe fully) _____



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SUBJECTIVE COMPLAINTS - PAGE 2

Please check all of the appropriate symptoms that you now have or have had recently by frequency. We want all of the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff. Please letter the line beside the symptoms which pertain to you with an **O = OCCASIONAL**, **F = FREQUENT** or **C = CONSTANT**. If you do not have a symptom **leave it blank**.

General Symptoms:

- Headaches
- Allergy headaches
- Migraine
- Tension
- Fever
- Chills
- Fainting
- Convulsions
- Nervousness
- Loss of weight
- Obesity
- Loss of sleep
- Numbness / Pain in arms / hands
- Numbness / Pain in legs / feet
- Allergy
- Wheezing

E.E.N.T.:

- Failing vision
- Near sightedness
- Far sightedness
- Eye pain
- Deafness
- Earache
- Ear discharge
- Nosebleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Enlarged glands

Skin:

- Skin eruptions
- Psoriasis
- Eczema
- Itching
- Bruise easily
- Dryness
- Varicose veins
- Hives/allergy

Respiratory:

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficulty breathing

Cardiovascular:

- Rapid heart beat
- Slow heart beat
- High blood pressure
- Low blood pressure
- Pain over heart
- Swelling of ankles
- Poor circulation

For Women Only:

- Lumps in breast
- Congested breast
- Vaginal discharge
- Painful menstruation
- Pre-menstrual headache
- Excessive flow
- Irregular cycle
- Hot flashes
- Menopausal symptoms
- Infertility
- Previous discharge

CURRENT pregnancy

Last menstrual cycle was: _____

Genitourinary Symptoms:

- Frequent urination
- Painful urination
- Blood in urine
- Kidney/bladder infection
- Bed wetting
- Inability to control bladder
- Prostate trouble
- Inability to start urination

Gastrointestinal:

- Poor appetite
- Difficult digestion
- Excessive hunger
- Belching/gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Distension of stomach
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

Muscle / Joint Symptoms:

- Hernia
- Arthritis
- Swollen Joints
- Painful joints
- Difficulty walking
- Backache / Sciatica
- Painful tailbone
- Neck pain / stiff neck
- Pain between shoulders
- Muscle spasms

To help us better explain chiropractic and how we may be able to help you, please check the one best answer for each statement below:

1. The primary reason I brush my teeth is to _____.
 avoid tooth decay and gum disease
 make sure I have healthy teeth and gums
2. When I make decisions I generally _____.
 gather the facts and weigh the evidence
 consult my friends and family
 depends on how I feel about it
3. When I get in an automobile, I put on my seatbelt _____.
 every time most of the time some of the time

Your Name: _____

Signature: _____

Age: _____ Today's Date: _____

Occupation: _____

File #: _____

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