

**Serenity Chiropractic Health
421 Penbrooke Drive Suite #3
Penfield, New York 14526**

Patient and Insurance Information

Name: _____ Sex: M F Date: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Beeper/Cell: _____
D.O.B.: _____
Employer: _____ Occupation: _____

Health Insurance Info (If insurance card not present)

Carrier: _____ Ins. Co. Phone: _____
Address: _____
Policy #: _____ Group #: _____
Patient Relationship To The Insured: Self Spouse Child Other

* If you are covered under another person's insurance, please complete.

Name of Insured: _____
Address of Insured: _____
Phone of Insured: _____ Sex: _____ D.O.B. _____
Insured's Employer: _____
Address: _____
Phone: _____ Plan Name: _____

Auto Accident Insurance (Fill out ONLY if auto accident)

Carrier: _____ Policy Number: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Person to Contact: _____ Claim #: _____
Date of Accident: _____ Patient Relationship To The Insured: Self Spouse Child Other

Chiropractic Case History

Name _____ Date _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade of pain

right now: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

at its worst: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

at its best: (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication

Reason for taking

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

E. Surgeries:

Date

Type of Surgery

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death

Age at death

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

6. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date

Financial Policy

Serenity Chiropractic Health accepts the following Insurance:

- Excellus BCBS
- NYS No Fault
- CIGNA
- Medicare Part B Assignment
- MVP
- United Healthcare

Serenity Chiropractic Health accepts the following payment types:

- Cash, check or money order
- Major credit cards/ debit cards/ Flex cards
- PayPal online payments (Including the ability to pay with a credit card)

Although we may not accept assignment for your insurance, many insurance plans do cover chiropractic care to some extent, and we are happy to provide you with all necessary paper claims, office notes, treatment plans, etc. to enable you to receive the maximum reimbursement from your insurance company. In some cases insurance will not cover care, or cover only a limited portion of that care. In these cases, many people opt to use a HSA (Health Savings Account) or Flex Plan* offered by their employer.

In cases of financial hardship, the staff at Serenity Chiropractic Health will be happy to work out an appropriate payment plan.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Payment Agreement: (please initial)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B _____ I have insurance that is **not** on the above list, but I wish to file my claims personally, and agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

C _____ I have insurance that Serenity Chiropractic Health participates with and agree to pay all required deductibles and co-pays at the time of service.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature

Date

* Flex Plan or Flexible spending accounts (FSAs) allow you to deduct pretax money from your paycheck and get reimbursed for health-related expenses up to an amount set by your employer -- typically a few thousand dollars. This can result in a savings of hundreds of dollars in federal taxes for many individuals if you use this money for health care spending. Ask your employer to see if such a plan is offered at your place of employment.

SERENITY CHIROPRACTIC HEALTH
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Serenity Chiropractic Health
Print Name

Office's Notice of Privacy Practices **AND** consent to all legitimate uses and disclosures of protected health information as described in the Notice.

Signature of Patient

Date