PATIENT INFORMATION

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

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

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Emergency Contact: _____ Relationship:_____ Phone Number: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____

Reason for visits: _____ How did you respond? _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? _____ What activities? _____

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much? _____

Do you drink coffee? Yes No How many cups per day? _____

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

Medications: Name, dosage, frequency, reason for taking

_____

_____

_____

Surgeries: Date/type of surgery

_____

_____

Females: Pregnancies/Date of Delivery/Outcome

_____

_____

Family Health History: Do you have a family history of? (Circle all that apply)

Cancer Strokes Heart disease Arthritis Diabetes Psychiatric disease Other: _____

Adopted/Unknown

Cause and age of parents or siblings death

_____

_____

_____

CERVICAL SPINE (NECK):
Do you experience?

- ☐ Neck pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in your arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Low energy/Fatigue
- ☐ TMJ/Pain/Clicking

THORACIC SPINE (MID BACK):
Do you experience?

- ☐ Mid back pain
- ☐ Pain on deep inspiration/expiration
- ☐ Pain into ribs/chest
- ☐ Indigestion/Heartburn
- ☐ Shortness of Breath
- ☐ Reflux

LUMBAR SPINE (LOW BACK):
Do you experience?

- ☐ Low back pain
- ☐ Leg weakness
- ☐ Injuries to hips/knees/ankles
- ☐ Pain into hips/knees/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Constipation/Diarrhea
- ☐ Sexual dysfunction
- ☐ Urinary dysfunction

REVIEW OF SYSTEMS

Have you had any of the following problems?

PULMONARY (LUNG-RELATED)

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema

NEUROLOGICAL (NERVE-RELATED)

- ☐ Visual changes/loss of vision
- ☐ History of seizures
- ☐ One-sided weakness of face or body
- ☐ One-sided decreased feeling of face or body
- ☐ Memory loss
- ☐ Vertigo
- ☐ Strokes/TIAs
- ☐ Loss of sense of smell

RENAL (KIDNEY-RELATED)

- ☐ Kidney stones
- ☐ Blood in the urine
- ☐ Bladder infections
- ☐ Difficulty controlling urine
- ☐ Kidney disease
- ☐ Dialysis

HEMATOLOGICAL (BLOOD-RELATED)

- ☐ Anemia
- ☐ Sickle-cell anemia
- ☐ Hemophilia
- ☐ Regular anti-inflammatory use (ibuprofen/motrin/aleve)
- ☐ Abnormal bleeding/bruising
- ☐ Anticoagulant therapy
- ☐ Hypercoagulation
- ☐ Deep Vein Thrombosis

PSYCHOLOGICAL

- ☐ Psychiatric diagnosis
- ☐ Depression/Suicidal Thoughts
- ☐ Bipolar disorder
- ☐ Schizophrenia

CARDIOVASCULAR (HEART-RELATED)

- ☐ Heart Surgeries
- ☐ Congestive heart failure
- ☐ Murmurs or valvular disease
- ☐ Heart attacks
- ☐ Hypertension
- ☐ Pacemaker
- ☐ Irregular heartbeat

ENDOCRINE (HORMONE-RELATED

- ☐ Thyroid dysfunction
- ☐ Hormone replacement therapy
- ☐ Diabetes

GASTROENTEROLOGICAL (STOMACH-RELATED

- ☐ Nausea
- ☐ Difficult swallowing
- ☐ Ulcers
- ☐ Frequent abdominal pain
- ☐ Hiatal hernia
- ☐ Irritable bowel
- ☐ Hepatitis or liver disease

DERMATOLOGICAL (SKIN-RELATED)

- ☐ Significant burns
- ☐ Significant rashes
- ☐ Skin grafts
- ☐ Psoriatic disorders

MUSCULOSKELETAL (BONE/MUSCLE RELATED)

- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Broken bones
- ☐ Spinal fracture
- ☐ Spinal surgery
- ☐ Scoliosis
- ☐ Joint surgery

Is there anything in your past medical history that you feel is important to your care here? _____

_____

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's name: _____ If patient is a minor, Parent's name: _____

Signature: _____ **Date**: _____

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click" or "pop", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

·Spinal Manipulative Therapy	·Palpation	·Vital Signs	·Range of Motion Testing
·Orthopedic Testing	·Ultrasound	·Postural Analysis	·Muscle Strength Testing
·Hot/Cold Therapy	·EMS	·Radiographic Studies	·Basic Neurological Testing
·Massage Therapy	·Manual Therapy	·Myofascial Release	·Trigger Point Therapy

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complication include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. Some patients may feel some stiffness and soreness during the first few days after treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone which I check for during the taking of your history, examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare, and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options may include, but are not limited to:

·Self administered, over-the counter analgesics and rest
·Medical care and prescription drugs such as anti-inflammatory, muscle relaxers and pain killers
·Hospitalization
·Surgery

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reverse mobility, which may cause a pain reaction further reducing mobility. Over time, this process may complicate treatment making more difficult and less effective the longer it is postponed.

For Women only

To the best of my knowledge I (am _____) / (am NOT _____) pregnant and any staff member of Nurture Chiropractic Company, PLLC, has my permission to x-ray me for diagnostic interpretation. _____(please initial)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have the above explanation of the chiropractic adjustment and related treatment. I have discussed/ will discuss it with Dr. Jasmine Thompson and have had/ will have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved with undergoing treatment and decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consents to that treatment.

Patient's Name:_____ If patient is a Minor, Parent's Name:_____

Signature:_____ **Date:**_____-_____

Doctor's Name: Jasmine Thompson, DC **Doctor's Signature:**_____

FINANCIAL POLICY

Services and Fees			
Spinal Adjustment	$50	Cervical Spine X-Rays	$60
Initial Exam (Adult)	$55	Thoracic Spine X-Rays	$50
Initial Exam (Pediatric)	$30	Lumbar Spine X-Rays	$50
Progress Exam (Adult)	$30	Laser/Stim/Traction	$40

This agreement is between Nurture Chiropractic Co. PLLC as creditor, and the Patient/Debtor named on this form.

Payment Options: ALL PAYMENTS ARE DUE ON THE DAY THAT THE SERVICES ARE RENDERED. **You may choose to pay cash, check or credit card.** There is a fee (currently $35.00) for any checks returned by the bank and may be turned over to the District Attorney's office for restitution.

Insurance: Dr .Jasmine Thompson is in-network with BlueCross BlueShield, Ambetter, United Health Care, and Medicare. Nurture Chiropractic Co. will bill these insurances on your behalf. If you have a carrier other than these stated that contributes to chiropractic care please inform us. In most cases we can give you a super bill to turn in to your insurance company for possible reimbursement.

No-Show Policy: We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a scheduled appointment, please let us know **in advance**. A No-Show is when a patient fails to keep a scheduled appointment. A No-Show will generate a **$25** fee and three no shows may require that you seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. If you are a walk-in patient, please understand that there are patients who have scheduled appointments, and you will be seen at the next available time slot. We strongly encourage you to call the office for an appointment first. The No-Show fee will be charged directly to the patient/guardian, NOT the patient's insurance company or Medicare. All No-show fees must be paid prior to the next appointment in order to be seen and cannot be paid with any Health Benefit Savings cards or Discount Medical Plans. If not paid, this balance can be turned over to our collection agency.

Patient's Name:_____ Date:_____

If patient is a Minor, Parent's Name:_____

Signature:_____

NURTURE CHIROPRACTIC COMPANY
103 W Colt Square Drive
Fayetteville, AR 72703
(479) 966-2043

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Nurture Chiropractic Company or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature		Date
Print Patient's Full Name		Time