Sheaffer FAMILY CHIROPRACTIC

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Cell phone:**
Work phone:	**May we contact you at work?** Yes ☐ No ☐
Best time/place to contact you:	**Email:**
Date of birth:	**Age:**
No. of children:	**Pregnant?** Yes ☐ No ☐ **Not Applicable** ☺ ☐
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account, if not the patient:	
Do you have insurance that covers Chiropractic care? Yes ☐ No ☐	**Do you have Medicare coverage?** Yes ☐ No ☐
Name of Insurance Company:	
*** If you would like us to look into your insurance, we will need a copy of your insurance card**	

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the ***"General Health History"****.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms (Please explain):

_____

_____

Which activities aggravate your condition? _____

_____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

What lesson(s) have you taken home from your healing process to date?

_____

_____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any conditions for which you are taking medications/drugs:

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) _____

_____

Stressors

Because accumulation of stress affects our health and ability to heal **please list your top three stresses (you have ever had) in each category**:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your emotional/mental health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

Why are you here at this point in time?

_____

_____

_____I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____

Signature: _____ Date: _____

Sheaffer Family Chiropractic

FINANCIAL AGREEMENT

Patient's Name_____ SS#_____-_____-_____

Policy Holder Name _____ Policy Holder SS#_____-_____-_____

Policyholder Date of Birth____/____/_____ Phone#_____

Insurance Co._____ Policy#_____ Group#_____

Relationship to Policyholder (circle) spouse child other Employer_____

Office Fees

Consultation	No Charge
Initial Exam/Computerized Neuro Spinal Exam	$40 (Sorry. This is *Not Covered by Medicare* !!)
Re-Exam/ Computerized Neuro Spinal Exam	$40 "
Adjustment	$38-55
Extremity Adjustment	$20
Flexion/Distraction –Mechanical traction	$20
Corrective/Wellness Adjustment Plans	Fees vary depending on # of people on a Plan

****FIRST VISIT FEES ARE DUE ON THE FIRST VISIT REGARDLESS OF INSURANCE.** *This allows time to verify your insurance so that everything will be clear from the beginning* (1st Visit Fee Range= **$40-82**.)

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. In accepting care you agree to the following:

I agree to pay for all services rendered to me at the time services are provided, unless I participate in one of the available Corrective Adjustment Plans (CAP), which are designed to be the most cost effective way to keep me and my family as healthy as possible.

- I acknowledge responsibility for my account and guarantee payment of all charges.
- I understand that any portion of the account balance over 90 days old will be submitted to a collection agency and subject to a finance charge of 1.5% per month (18% annually)
- I agree in the event of non-payment to bear the cost of collections and/or court costs and reasonable legal fees, should this be required.

If I have health insurance:

- I understand and agree that health and auto insurance policies are an agreement between the insurance carrier and myself.
- I understand that this chiropractic office will assist me with any information, or forms needed for me to personally file for reimbursement from my carrier.
- I understand that under special agreement or as a participant of a CAP, this office may file my insurance claims for me. In this event: I authorize Sheaffer Family Chiropractic to release necessary information to my insurance carrier; to verify my benefits; and to accept assignment of benefits.
- I acknowledge that verification is not a guarantee of coverage, since final benefits will be determined upon receipt of the claim.
- I understand that any claim denied by my insurance carrier, ultimately leaves me responsible for payment of services rendered

I have read, understand and agree to the above policies.

Signature of Responsible Party_____ Date_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Notice of Privacy Policies

(HIPPA Requirement)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review It Carefully.

Our commitment here at Sheaffer Family Chiropractic is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associated and/or for payment purposes. The following are examples of instances where information may be shared:

- **During treatment, if you feel the need for a private adjustment we can accommodate.**
- **For payment purposes, we do electronic billing and your information is protected by a firewall system.**
- **Your file is a personal record and will not be released without your signature.**

We here at Sheaffer Family Chiropractic are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Policies. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The written authorization may be revoked at any time by the individual, as provided for by law. You are entitled to a copy of these policies at your request.

If you have any questions regarding your Protected Health Information, feel free to contact our Compliance Officer, Pamela Grimes, at (717) 843-9355

I have read and understand the above Notice of Privacy policies.

Signature_____Date_____