Welcome to Southiere Chiropractic Associates
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www.southierechiropractic.com

New Patient Information Sheet

Date:_____

Thank you for choosing Southiere Chiropractic. Please take a few moments to complete the following information.

Personal Information

Last Name _____First Name _____

Address _____ Apt _____

City _____ State _____ Zip _____

DOB _____ Sex: M / F SSN# _____

Email Address _____

Home/Cell phone _____Work phone _____

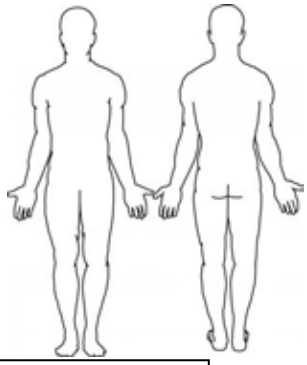
Occupation/Type of work _____

Marital Status **S D M W**

Whom may We thank for referring you?

_____

Mark your area of concern



In case of an emergency we should contact this person.

Contact Name _____ Relationship _____

Home/Cell Phone _____

Reason for Visit

Major Complaint? _____ When did this first occur?_____

Are the Symptoms getting progressively worse? Y/N

Rate the severity of the problem **1 2 3 4 5 6 7 8 9 10** (mild to severe)

Is the problem ☐ occasional ☐ frequent ☐ constant

What helps the condition? _____

What worsens the condition? _____

Any other symptoms/complaints? _____

Financial Section

☐ *I have insurance that might cover some of the cost of my care*

Insurance Company Name _____

Insurance Policy ID # _____

Group # _____

Please continue on other side

Please mark each symptom or condition you *presently* have or *previously* had:

General Symptoms
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache / Migraine
- ☐ Cancer
- ☐ Diabetes

Muscles & Joints
- ☐ Low Back Problems
- ☐ Osteoporosis
- ☐ Pain between Shoulders
- ☐ Arthritis
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Sore Muscles
- ☐ Walking Problems
- ☐ Arthritis

Cardio-Vascular
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pain over Heart
- ☐ Poor Circulation
- ☐ Strokes
- ☐ Pacemaker
- ☐ Anemia

Ear/ Nose/ Throat
- ☐ Earache
- ☐ Ear Noises
- ☐ Enlarged Thyroid
- ☐ Sinusitis
- ☐ Cataracts
- ☐ Pain Behind Eyes
- ☐ Glaucoma
- ☐ Poor Vision

Gastro-Intestinal
- ☐ Weight Loss/ Gain
- ☐ Bloody Stool
- ☐ Black Stool
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Alcoholism
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Ulcer
- ☐ Poor Digestion

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Emphysema

Genito-Urinary
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Loss of Bladder
- ☐ Kidney Infection
- ☐ Prostate Problems
- ☐ Loss of Bladder

Skin or Allergies
- ☐ Eczema/ Rash/ Dermatitis
- ☐ Dryness
- ☐ Boils
- ☐ Bruising Easily

For Women Only
- ☐ Hormone Replacement
- ☐ Birth Control
- ☐ Pregnant now **Y/N**

Exercise	**Work Activity**	**Habits**
☐ None	☐ Sitting	☐ Smoking Packs / Day _____
☐ Moderate	☐ Standing	☐ Alcohol Drinks / Week _____
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks Cups / Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level
		Reason_____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform **Southiere Chiropractic** of any changes in my health.

I agree to assign all insurance benefits directly to **Dr. Southiere**. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. **Southiere Chiropractic** may use my health care information and may disclose such information for the purpose of obtaining payment for services and determining insurance benefits. This consent is continually active unless revoked in writing.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

INFORMED CONSENT DOCUMENT

Patient_____

To the patient: Please read this entire document prior to signing it. It is important that you under stand the information that is contained in this document. Please ask any questions, if anything is unclear before you sign it

The nature of the chiropractic adjustment.

The primary treatment that I use as a Chiropractic Physician is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument to move the joints of your body. That may cause and audible "pop" or "click", much like when you "crack" your knuckles. You may feel a sense of movement.

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 complications include but are not limited to: fractures, dislocations, disc injuries, muscle strains, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulations have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment, I will make every 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 some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stoke has been the subject of tremendous disagreement and debate. These 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.

(over)

The availability and nature of other treatment options.

Other treatment options for you condition may include:

Self –administered, over the counter analgesics and rest
Medical care and prescriptions drugs
Hospitalizations
Surgery

If you chose to use one of the above mentioned noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

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

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

PLEASE CHECK THE APPROPRIATE BLOCKS AND SIGN BELOW.

I have read [ ] or had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Southiere 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 here by give my consent to that treatment.

Dated:_____ Dated:_____

Dr. Richard N. Southiere

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian
(if a minor)

Financial Policy

Our experience has shown us that it is beneficial to have an understanding with our patients on office policy's and procedures. We do not base your treatment plan on your insurance coverage, and we believe you shouldn't either. Dr. Southiere will recommend treatment based on his findings, proper medical protocol, and what he believes will give you the best results.

We do not bill our patients repeatedly (if we are forced to bill you repeatedly, there will be a ***$10.00*** service charge.) We will do our best to keep you informed regarding your account. We will submit claims to your health insurance, with the understanding you have provided us with the correct Health Insurance information. It is your responsibility to notify us if there have been any changes with your health insurance, auto accident, or work related injury coverage.

We will attempt to verify your coverage and base the amount you pay at the time of service on that information. This is not a guarantee that your insurance will pay. Please keep in mind***; Co pays are due at the time of service.***

Unless prior arrangements are made in advance, no patient is allowed to have a personal balance due on their account greater than ***$300.00.***

I understand that my Health Insurance Policy is between myself and my Health Insurance Company

I understand that I am responsible for providing accurate and current Health Insurance information at the time of service

I understand I am financially responsible for any and all services denied by my Health Insurance including any non covered charges, deductibles, and co pays.

If your account is sent to collections, (Asset Recovery) you will be responsible for the 30% collection fee.

We offer several methods of payment for your care, making it convenient not to carry a balance due on your account.

Today's payment will be made by: (circle one) Cash Check Credit Card

I have read and understand this policy. I agree to the terms outlined above.

_____	_____	_____
Print name	Signature	Date

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____