washington square
chiropractic center

604 WASHINGTON SQUARE SOUTH ● PHILADELPHIA, PA 19106 ●(215) 925 8005
washingtonsquarechiro.com

DATE: _____

_____ _____ _____
YOUR First Name | Your Last Name | Your Birth Date

_____ _____ _____
IF PATIENT IS A MINOR: Patient's First Name | Patient's Last Name | Patient's Birth Date

_____ Sex: ☐ Male ☐ Female ☐ Trans Marital Status: ☐M ☐S ☐Ptnr ☐D ☐W
How do you prefer to be addressed?

_____ _____ _____
Address (to receive mail) | City, State | Zip Code

( ) _____ ( ) _____ _____
Best Phone Number to Contact You | Next Best Phone Number to Contact You | Email Address

( ) _____ _____ _____
Emergency Contact Number | Name of Emergency Contact | Their Relationship to You

_____
What is your main reason for seeking chiropractic care today?

Please place a mark along the line below indicating how much this problem is affecting your life:

0_____**10**
Zero (No effect on my life) | Ten (Affects my entire life negatively)

_____
In what way or ways does this problem affect your life?

Have you ever had chiropractic care before? ☐ Yes ☐ No How long ago? _____

_____ _____
Reason for discontinuing care | Are there any concerns you have about chiropractic care you would like us to address?

_____ _____
Your occupation | Hobbies, Interest, Activities and if these are affected by this problem

Do you have (or had) any of the following: ☐ Arthritis ☐ High Blood Pressure ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ HIV related or other Neuropathies **Do you take any blood thinners such as Coumadin or Warfarin?** ☐ Yes ☐ No

_____ _____
Please list any surgeries you have had and in what year | Please list any fractures or serious injuries and year

_____
Is there anything else you would like us to know about you or your condition or any other concerns we may address?

All of the above is true to the best of my knowledge: _____ _____
Signature | Date

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DAILY ACTIVITIES WORKSHEET

Patient Name: _____ Date:_____

Place a mark along the line of only those activities that are affected:

ACTIVITY	Slight----------Can't Effect Perform	Comments or Explanations
Sleeping	|----------|	_____
Rising from bed	|----------|	_____
Brushing your teeth or washing your face	|----------|	_____
Getting dressed	|----------|	_____
Driving or other commuting	|----------|	_____
Working at desk	|----------|	_____
Job related activities	|----------|	_____
Rising from sitting	|----------|	_____
Childcare	|----------|	_____
Preparing food	|----------|	_____
Watching TV or reading	|----------|	_____
Exercising - aerobic	|----------|	_____
Exercising - resistance/weights	|----------|	_____
Hobbies	|----------|	_____
Sexual activity	|----------|	_____
Anything Else? _____	|----------|	_____

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ACKNOWLEDGEMENTS

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including examinations, chiropractic adjustments, and supportive therapies and instructions on myself or on the patient named above for whom I am legally responsible by Washington Square Chiropractic Center, LLC and/or other support staff who now or in the future treat or examine me while employed by, work for or are associated with or serving as back-up providers for Washington Square Chiropractic, LLC. I have had an opportunity to discuss with the Washington Square Chiropractic Center, LLC provider and/or other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment including but not limited to temporary muscle spasm, aggravation and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Washington Square Chiropractic Center, LLC provider to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are other treatment options available for my condition. These treatment options include but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and, by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s).

Name: _____Signature: _____ Date: _____

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____	_____	_____
Your Name	Signature	Date

Initials: X_____ I may request of copy of the Privacy Policy and I understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties

Initials: X_____ I grant permission to be called to reschedule an appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

Initials: X_____ My records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize Washington Square Chiropractic Center, LLC to release any information requested by any insurance company, attorney or any doctor that is relevant to my examination and treatment. I also authorize the payment of medical benefits directly to Washington Square Chiropractic Center, LLC if my insurance is accepted by Washington Square Chiropractic Center, LLC.

Initials: X_____ To the best of my knowledge and ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

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FINANCIAL POLICY

Please Read

I understand and agree that health insurance and accident insurance policies are an arrangement between me and an insurance company.

I understand that for the benefit and convenience of its clients, Washington Square Chiropractic Center (WSCC) has enrolled in a number of managed care plans which are offered by insurance companies and that WSCC's agreement with an insurance company is that WSCC will bill for and accept the benefits offered by the company for treatment during the period of time and/or for the number of visits offered by that company's managed care plan.

I understand and agree that in many cases, the time frame and number of visits may fall short of the time and number of visits required for *complete* correction and healing of conditions such as mine and that the coverage time/number of visits allowed is determined by an insurance company's use of statistics that determine average time and numbers of treatments to achieve relief of acute pain and often the *initial* healing phase of a condition and not necessarily true and complete health and wellness as can be achieved through chiropractic care.

I understand and agree that my doctor of chiropractic at Washington Square Chiropractic Center will make recommendations for care based solely on his or her clinical knowledge and experience in order to lead to complete healing and optimal physical function and <u>not</u> on the pain relief and initial healing phase allowances determined by most insurance companies.

I understand and agree that should I choose to continue care, as recommended by my doctor, beyond that which is allowed by my insurance company or if my insurance policy does not cover chiropractic care or if I do not have health or accident insurance coverage that I am responsible for the cost of treatment at Washington Square Chiropractic Center as follows:

Initial Examination:	$50
Chiropractic Adjustment:	$45
Home care instructions, Exercise and Stretching Instructions:	No Charge
Interim Examination:	No Charge

Patient's Name: _____

Patient's/Guardian's Signature: _____ Date: _____