Pierce Chiropractic

STEVEN PIERCE DC

Welcome

Today's Date: ____/____/____

Patient Name: _____
Last First MI

Date of Birth: ____/____/____ Age: _____

Mailing Address: _____

_____
City State Zip

Home Phone #: _____

Work Phone #: _____EXT: _____

Other Phone / Cell: _____

Employer: _____How Long? _____

Occupation: _____

Status: Minor / Single / Married / Divorced / Separated / Widowed

Spouse's Name: _____

Do you have children? Yes / No How Many? _____

Reason for Visit

Please describe the pain & its location: _____

_____

When did Condition begin? ____ / ____ / ____

Is this condition getting: Better / Worse / Staying the Same?

Is this condition: Constant / Comes & Goes?

Have you had this or similar conditions in the past? Yes / No

If so, please explain: _____

_____

Have you been treated by a Medical Physician for this condition?

Yes / No If so, where? _____

Have you ever been treated by a Chiropractor before? Yes / No

If so, where? _____

Who referred you to our office? _____

Health History

Do you have or ever had any of the following diseases or conditions?

Y / N	Heart Attack / Stroke	Y / N	Heart Surg. / Pacemaker	Y / N	Heart Murmur
Y / N	Congenital Heart Defect	Y / N	Mitral Valve Prolapse	Y / N	Artificial Valves
Y / N	Alcohol / Drug Abuse	Y / N	Venereal Disease	Y / N	Hepatitis
Y / N	HIV+ / AIDS	Y / N	Shingles	Y / N	Cancer
Y / N	Frequent Neck Pain	Y / N	Emphysema / Glaucoma	Y / N	Anemia
Y / N	High / Low Blood Pressure	Y / N	Psychiatric Problems	Y / N	Rheumatic Fever
Y / N	Severe / Frequent Headaches	Y / N	Kidney Problems	Y / N	Ulcers / Colitis
Y / N	Fainting / Seizures / Epilepsy	Y / N	Sinus Problems	Y / N	Asthma
Y / N	Diabetes / Tuberculosis	Y / N	Difficulty Breathing	Y / N	Chemotherapy
Y / N	Lower Back Problems	Y / N	Artificial Bones / Joints	Y / N	Arthritis

Past Surgeries: _____

_____

_____

Past Accidents: _____

_____

_____

Please list any other serious medical condition(s) you have or had: _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Adult / Parent or Guardian / Spouse Date: ____ / ____ / ____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Pierce Chiropractic
1736 S. Jackson
Jacksonville, TX 75766

OR

If my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make out the check to me and mail is as follows:

C/O
Pierce Chiropractic
1736 S. Jackson
Jacksonville, TX 75766

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, doctor, hospital, or attorney involved in this case.

Dated _____

X _____
Signature

Informed Consent Document

Patient Name: _____

To the Patient: 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 used by doctors 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 "pop" or "click," 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, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, radiographic studies if necessary.

The risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may rise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations. muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation 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 will feel some stiffness and soreness following the first few days of treatment. The Doctor 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 the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unffotunate1y, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.
Other treatment options for your condition may include:

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

If you chose to use one of the above 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 which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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 care has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is 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 vertebrae 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 maximal health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend 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 advise regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.**

To the best of my knowledge, I am NOT PREGNANT and Steven Pierce, D.C. has my permission to x-ray me for diagnostic interpretation.

Signed: X_____

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Steven Pierce, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE
I have read or have had read to me. I the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Steven Pierce, D.C. 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 hereby give my consent to that treatment.

Dated _____ Dated _____

_____ Steven Pierce, D.C.
Patient Name Doctor's Name

X_____ _____
Signature Signature

_____
Signature of Parent or Guardian (If a minor)

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print* name** of Patient Please ***sign* name** of Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer