ProActive Chiropractic

Back to Work
Back to Play

Date of first visit _____

Patient Information

First Name _____ M.I. _____ Last _____

Name you would prefer to be called _____

Address _____ City _____ ZIP _____

Gender you identify as _____ Your Birthdate _____

Primary phone _____ Secondary phone _____

Email Address _____

In an emergency, contact _____ Phone _____

How did you hear about us? _____

_____

Are you willing to be an active participant in your health? ☐ Yes ☐ No

Have you ever seen a chiropractor before? ☐ Yes ☐ No

Are you under a medical doctor's care? ☐ Yes ☐ No

If yes, doctor's name _____

Is it ok for us us to contact your doctor to coordinate care? ☐ Yes ☐ No

Doctor's contact phone _____

Have you ever been in an automobile accident? (if yes, explain) _____

_____

_____

Are you currently working? ☐ Yes ☐ No

Job title _____ Hours per week _____

Employer Name & Address _____

At your job, what do you do most of the time? ☐ Sit ☐ Stand ☐ Bend ☐ Twist

How much do you lift at work? ☐ 0-10 lbs ☐ 10-25 lbs ☐ 25-50 lbs ☐ 50+ lbs

How often? ☐ Occasionally ☐ Frequently ☐ All the time

Do you use a computer? ☐ Yes ☐ No If yes, how many hours per day? _____

Do you have Medicare? ☐ Yes ☐ No

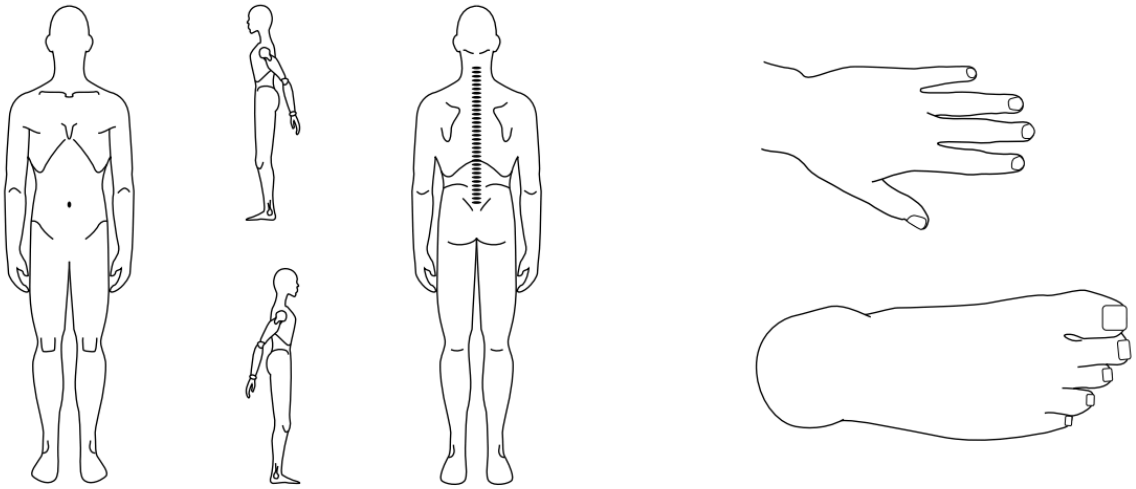
If yes, is Medicare your primary insurance? ☐ Yes ☐ No

☐ I plan to pay in full each visit by cash, check, or Visa/MasterCard.

☐ I am interested in prepaying for treatment in order to receive a discount.

Your chief complaint _____

Please mark all areas of complaint



Check any type of medical problem you may have ☐ NONE

☐ Headaches/Migraines	☐ Sleep Problems	☐ Fatigue	☐ Sinus/Allergy
☐ Asthma/Breathing Problems	☐ Stomach/Digestion	☐ Thyroid Issues	☐ Cancer
☐ High/Low Blood Pressure	☐ Bowel Problems	☐ Kidney/Bladder	☐ Diabetes
☐ Heart condition	☐ Stroke	☐ Carpel Tunnel	☐ Hormonal Complaints

Surgeries _____

_____

Medications (include non-prescription) _____

_____

Supplements/Vitamins _____

_____

Any known allergies (drugs, antibiotics, food, etc) _____

_____

Relevant Family History _____

_____

Do you smoke? ☐ Never smoked ☐ Former smoker ☐ Current smoker

Date stopped _____ Amount per day _____

# of years smoked _____

FOR WOMEN ONLY

Pregnant? ☐ No ☐ Yes If yes, what is your due date _____

How much do you drink of the following per day (cups / ounces)?

Coffee _____ Water _____ Soda _____ Energy Drinks _____

Alcohol _____ Juice _____ Milk _____ Tea _____

What position do you sleep in the most? ☐ Back ☐ Left side ☐ Right side ☐ Stomach

Exercise What kind and how often? _____

_____

I have reviewed the information on this document and it is correct. I recognize that I am ultimately responsible for my bill. I have read, or have had read to me, the informed consent document. I have also had an opportunity to ask questions about its content, and by signing below I agree to the named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also have read the HIPPA agreement. Copies of both theInformed Consent and HIPPA agree are always available upon request or from the website.

Patient Signature _____ **Date** _____

I, the undersigned, have voluntarily requested that the doctors of chiropractic at ProActive Chiropractic Cohen Corp, (herein 'the doctors' and 'ProActive Chiropractic'), assist me in the management of my health concerns. I understand that the doctors are chiropractors and that their services are not to be construed or serve as a substitute for standard medical care. The doctors recommend that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, and osteopaths who perform manipulation are required by law to obtain your informed consent before starting treatment. I, the undersigned, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physiotherapy modalities (ex: Graston Technique, motor nerve stem, cold laser, etc), in-office exercises, taping, nutritional supplements/dietary recommendations, among others, may also be used. Routine chiropractic examination and treatment involve some of the following methods:

- Observation and Inspection: Viewing/looking at body parts. Visualization includes general body viewing in a standing position from the front, back, and side. All symptomatic (painful) body parts may be viewed. Although not usually required, if clothing interferes with the examination or treatment of an area patient gowning will be utilized. Patients may request an observer of the opposite sex be present at any time during examination and/or treatment.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Using a rubber hammer and tapping on bones or tendons
- Orthopedic neurological testing: These are the standard tests to assess your neuromusculoskeletal systems.
    - Muscle testing: testing muscles for weakness and/or pain with contraction.
    - Myofascial and/or Graston Technique: muscle work sometimes involving tools to increase flexibility and break up adhesions in muscle or myofascial tissues.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment

Soreness: I am aware that like exercise it is possible to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the doctor if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. A 2009 study of 100 million person-years found "no evidence of excess risk of stroke associated with chiropractic care compared to primary care." I f you have any questions about this, please ask the doctor. We would be happy to discuss other options and answer any of your questions.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

(continued on next page)

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or ov er-the-counter medications, exercises and possible injections and/or surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

We cannot advise you regarding any medication/s. Please consult your M.D.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective in injured serve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information.

I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Patient's Signature _____ Date _____

I discussed the procedures, alternatives, and risks in conference with the patient.

Doctor's Signature _____ Date _____

Missed Appointment Policy

At ProActive Chiropractic, we respect your time and pride ourselves in our extremely short wait times (if any). We do this by scheduling responsibly. In order for us to maintain this high quality of service, we require patients give us a 24-hour warning if they will be unable to make their appointment. If a patient does not give us this warning period, which will allow us to fill their appointment spot, it is our policy to charge for the missed appointment.

I understand the above statement and either will give a 24-hour notice if I will be unable to make my appointment or I will pay for the missed appointment.

Signature _____ Date _____

Payment Agreement

Payment for the examination and treatment is required at the time of service. For your convenience, we accept cash, checks, Mastercard, and Visa. All fees are due at the time the services are rendered.

If you have chiropractic insurance, we are interested in you receiving the maximum benefits. As an added service to you, our office will provide you with a superbly for you to submit to your insurance company. However, please be advised:

1. Your insurance policy is a legal contract between you, your employer, and the insurance company. We, as healthcare providers, are NOT a party to that contract.

2. ProActive Chiropractic/Dr. Andrew Cohen is not a member of any HMO, PPO, or other provider network. Therefore, any coverage you may have for services provided in this office will be deemed “out of network coverage” by your insurance company.

3. Many insurance companies will advise you that your coverage will be a percentage, e.g. 80% of treatment charges, usually after a yearly deductible amount has been paid by you directly to us. What is often not specified by the insurance company are plan fee schedules, annual maximums, and other limitations that will have a direct bearing on the reimbursement allowed.

4. You remain ultimately responsible for all charges incurred in this office.

Signature _____ Date _____

HIPAA NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. This notice is available for review in the office and on the ProActiveSF.com website. We can also email or fax a copy if desired.

Please sign this form to acknowledge receipt of the Notice.

Patient Name _____ Date of Birth _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of ProActive Chiropractic Cohen Corp.

I understand that the Notice describes the uses and disclosures of my protected health information by ProActive Chiropractic Cohen Corp and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

Authorization for use/disclosure of information:

I am the patient, or legally authorized representative of the patient, listed above. I voluntarily authorize and direct ProActive Chiropractic Cohen Corp to disclose my health information to my email address during the term of this authorization. I understand that the specific purpose of this authorization is for Superbills, Report of Findings, and Health Service Agreement.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ *The patient refused to sign.*
- ☐ *Due to an emergency situation it was not possible to obtain an acknowledgement*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *Other (please specify)* _____