Premier Chiropractic
7113 W. Jefferson Blvd.
Fort Wayne, IN 46804

Financial/Treatment Consent Form

Please sign and complete for treatment.

Patient Information Today's Date: ____/____/_____

Name: Date of Birth

_____ _____/____/_____
Last First

Address: _____ City:_____

State:_____ Zip: _____

Marital Status: Married Single Widowed Divorced

Occupation _____

Home Phone (_____)_____ Cell (_____)_____

Email: _____

Emergency Contact _____ Phone (_____)_____

How did you hear about us?

Friend/Family Patient Doctor Referral Internet Other_____

Statement of Financial Responsibility and Authorization to Treat

I understand that I am financially responsible for all services rendered to me or my dependent at Premier Chiropractic. Premier Chiropractic does not bill insurance companies for direct payment to us nor do we file insurance claims for patient reimbursement. We will provide an insurance statement with the new chiropractic diagnostic codes for patients who submit their own claims. Claims may still be denied.

- This office does not submit claims electronically for insurance reimbursement.
- We are a non-Medicare provider and do not file or provide a statement for Medicare claims.
- This office does not accept Medicaid.
- Claims submitted by patients may or may not be reimbursed to you by your insurance company.
- Claims will not be filed by this office on behalf of any patient.
- It is the responsibility of the patient to maintain all of their own insurance receipts.

Patient Signature_____ Date____/____/_____

Authorization to Treat Cont.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Premier Chiropractic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. John McDonald and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

Patient Privacy Policy

The **HIPAA Privacy Rule** gives you a fundamental right to be informed of the privacy practices of our health plans, as well as to be informed of your privacy rights with respect to your personal health information. By signing this document, I acknowledge I have been offered a copy of the Notice of Patient Privacy Policy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's representative/guardian:

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Please List Any Current Conditions or Medications

Current Conditions:_____

_____

Medications:_____

_____

Past Medical History

Past Injuries	Description	Date

- **Car Accidents:** _____
- **Dislocation/Fractures:**_____
- **Head Injuries:**_____
- **Hospitalization**:_____
- **Surgeries**:_____
- **Trauma:**_____

When did you last have the following?

General Check-Up:_____

Who is your current family doctor?_____

Social History

Cigarette Smoking: Never Former: Quit Date_____ If you no longer smoke, how long did you smoke? _____
Current: Packs/Day_____ How long have you been smoking? _____

Do you drink Alcohol? No Yes Drinks per week? _____

Exercise Habits? Daily Weekly Never If yes, what type of exercise? _____

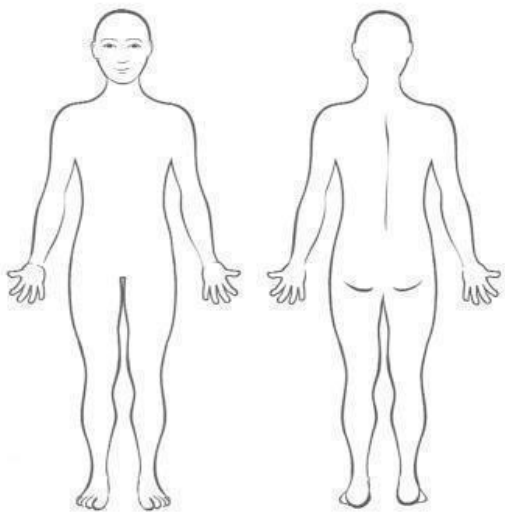
Do you drink caffeine (coffee, tea, soft drinks)? No Yes How many per day? _____

Work habits include mostly: Heavy Labor Light Labor Sitting Standing

PAIN CHART

Mark the areas on the diagram where you feel the described sensations.
Use the indicated symbols with the correlating sensation and include *all* affected areas.

Sensations:	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbols	----------	OOOOOOOO	XXXXX	*****	///////



Please ***write out*** which region of the body is affected separately on the numbered area lines below. Then **circle** the corresponding numerical value that indicates how much pain or discomfort you feel in that area.

Area #1: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #2: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #3: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Area #4: _____

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable