JESTER
FAMILY CHIROPRACTIC

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now, or in the future, treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office staff or clinic personnel the nature and purpose of chiropractic adjustments and 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, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravated and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved 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 not a promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing and surgery. I understand and have been informed that I have the right to a second opinion and secure other options 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 intent this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Patient: _____

Signature of Patient: _____

Date: _____

(If patient is a minor) Guardian/Parental Signature: _____

Doctor of Chiropractic Signature: _____ Date: _____

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Health History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Home situation: (circle, or add in writing): Single_____ Married (how long_____) Divorced (how long_____)
Widowed (how long_____) Domestic partnership_____ How many Children? _____ Children's Ages _____

Employment status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

SYMPTOM REVIEW:

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion /heartburn
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain / thumping of heart
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary / lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing
- ☐ hay fever
- ☐ frequent colds
- ☐ do you smoke: how much _____

Muscle / joint / bone
- ☐ swelling of ankles or legs

pain weakness or numbness in
- ☐ arms or hands or fingertips
- ☐ back or hips
- ☐ legs or feet or toes
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ dizziness
- ☐ headaches, migraines

Family History (Circle Which)
- ☐ Heart Disease: (mother / father)
- ☐ Cancer: (mother / father)
- ☐ Liver Disease: (mother / father)
- ☐ Diabetes: (mother / father)
- ☐ Depression: (mother / father)
- ☐ High Blood Pressure: (mother / father)
- ☐ High Cholesterol: (mother / father)
- ☐ Drug Use: (mother / father)

General
- ☐ weight gain / loss of 10+ lbs during last 6 months
- ☐ poor sleep / trouble falling asleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems / sinus headaches
- ☐ hoarseness
- ☐ allergies: list_____

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine
- ☐ difficulty urinating

Skin
- ☐ itching
- ☐ easy bruising
- ☐ sensitive skin

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ pregnant: #weeks _____
- ☐ bleeding between periods
- ☐ PMS / painful periods

Men only
- ☐ PSA

Personal
- ☐ Feeling unhappy and depressed
- ☐ Do you often cry
- ☐ Do you constantly worry about your health?
- ☐ Are you shy or sensitive?
- ☐ Do you wish you had someone to advise you?

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit? _____

Current weight: _____

Current height: _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

At Jester Family Chiropractic, PC, we are committed to protecting the privacy of your personal health information. Federal guidelines have been developed to protect this information. I understand that as a part of my health care, Jester Family Chiropractic, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results for diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care
- A means of communicating among the many health professionals who contribute to my care.
- A means by which third-party payers can verify that services billed match services provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have the option to be provided with a Notice of Information Practices that provides a more complex description of the information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object to the use of my protected health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Jester Family Chiropractic, PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations. I further understand that Jester Family Chiropractic, PC reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations, should Jester Family Chiropractic, PC change their notice they will send a copy of any revised notice to the address I have provided (U.S. Mail). I understand that in accordance and compliance with section 5b.5 and 5b.6 of the Code of Federal Regulations, I have the right to review or request access to my permanent records on file at Jester Family Chiropractic, PC. In order to access any part of my permanent records it is my responsibility to:

- Jester Family Chiropractic, PC will charge for copying records in accordance with Pennsylvania law, as applicable.
- Jester Family Chiropractic, PC will not send medical information by facsimile unless the information is needed for patient care and delay in the transmission of the information would compromise patient care.
- Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law.
- Jester Family Chiropractic, PC will make reasonable efforts to comply with this request **within thirty (30) days** for information that is maintained or accessible on site and within sixty (60) days for information that is not maintained on site. If Jester Family Chiropractic, PC is unable to comply with this request within the specified time periods, it may extend the applicable deadline for up to thirty (30) days by notifying you in writing.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health care information to another entity, and I consent such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

_____ _____

Patient's/Guardian's Signature Date

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Patient Acceptance of Care

In order to provide our best service and work toward achieving optimal results, all patients are accepted for care based in the following policies:

Care Plans: Care plans are individualized for each patient based on their individual needs, goals, and condition of their spine. It is the responsibility of the patient to follow their care plan to receive the full benefits of their program. Changes to care plans or visit frequency will be made at specific re-evaluations based on progress.

Appointments: Our policy is to make multiple appointments to ensure that we reserve the appointment time that is most convenient for you and we can most effectively manage our schedule. After each visit, always schedule at least one future visit. This will ensure you stick close to your care plan and continue to make progress. Never miss a visit because of finances or your ability to pay.

Missed Visits: Always call ahead if you cannot make your appointment. Please check your calendar a head of time and have a re-schedule time and date in mind to tell us, or the voice mail if we are out of the office. Emergencies are an exception. Never miss a visit because of finances or your ability to pay.

Financial Policies: Our fees for services are the same for all patients whether or not they are covered by insurance. All payments are expected at the time of service or by the end of the week. No patient may exceed a balance of $150.00. Outstanding balances will be requested to be paid by a credit card. Do the best you can financially.

Insurance: If we have verified your benefits and coverage and found out that you have applicable coverage for services in our office we will be glad to bill your insurance company for applicable claims. Insurance coverage is designed to cover care that is acute or chronic where improvement in function can be expected. Restorative therapy services are designed to be short term and goal directed. Transition to independent self-management is an important part of care that is considered maintenance or wellness in nature. Maintenance care is designed to keep you at the desired level of function that has been achieved and to protect the investment and progress in your spine and health. Maintenance care is not a benefit of most insurance plans and is excluded from coverage. Because this phase of care is so important, we make every effort to make this portion of your care affordable.

Massage: Please recognize that chiropractic massage therapy is for health maintenance and to clinically improve muscle tone and structure. It is for rehabilitation of the muscles and to help facilitate and restore normal muscle balance. We ask that you inform us of any existing problems or new issues that we should focus on, so your chiropractor and massage therapist can create a massage plan tailored to your needs. Please turn off all cell phones and other noise making devices during your massage. In an effort to accommodate everyone's scheduled appointment time, if you are late we can only provide you the time that is remaining for your massage. Because we reserve the time and room specifically for you, if you cancel or miss your appointment with less than 24-hour notice, you will be charged $25.00. Massage therapy is not covered under most chiropractic coverage and benefits. However, you may use HSA or FSA accounts to pay for massage therapy in this office. Payment is expected at the time of service. Patient's under the age of 18 can only receive massage with parental/legal guardian consent.

Do you have any questions or concerns about the above office policies? YES NO Explain: _____

Please sign below if you have read and understand the office polices. Thank you!

_____

Patient Signature Date Doctor's Initials

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Confidential Patient Information

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, completely and accurately. Thank you!

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Email: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Age: ____ Birth Date: _____ Heard about our office through/referred by: _____

Have you ever been to a Chiropractor? Y / N Last visit date: _____ Name of Doctor: _____

Occupation: _____ Employer: _____ Satisfaction with career: great okay unhappy

(Female) Are you Pregnant? Yes No Are your injuries related to: Work / Auto / Personal Injury / Other: _____

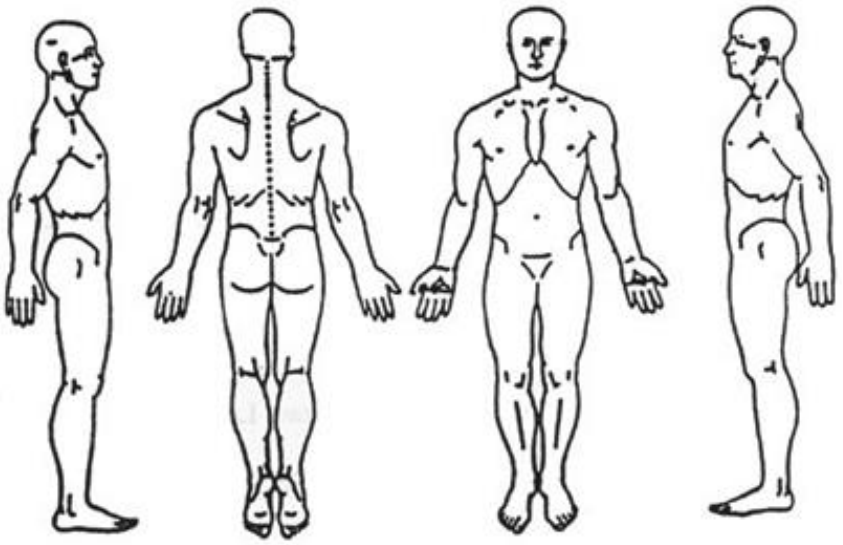
Please List Present Complaints and date of onset:

1. _____ 2. _____

3. _____ 4. _____

Please use the following symbols to write on the pain diagram to accurately describe your condition.

PPP – Where you experience pain
NNN – Where you experience numbness
TTT – Where you experience tingling
BBB – Where you experience burning
CCC – Where you experience cramping



Complaint history:
1. How long have you had this condition? _____ Date of onset: _____

2. How would you describe your pain? (circle all which apply) ache / burning / deep/ dull / tingling / numbness / sharp / shooting / superficial/ throbbing / tingling / tighness / numbness / mild / moderate / severe other: _____

3. How would you rate the intensity and range of your pain? (Circle the appropriate numbers)

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Moderate Pain) (Terrible Pain)

4. Pain radiates or travels? No Yes Where does it travel to: _____

5. How often is the pain present? Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Infrequent (>25%)

6. Since your problem began, is the pain: getting worse / getting better / staying the same

7. How did your problem begin? gradual / sudden / no specific reason / this is a flare up of an old problem

8. What makes your problem better? nothing / exercise / standing / sitting / ice / heat / resting / medication / massage

9. What makes your pain worse? nothing / exercise / standing / sitting / sleep / laying down / inactivity

10. What is your physical activity at work? Computer work / mostly sitting / light / moderate / heavy manual labor

11. What is your present mental and emotional stress level? none / minimal / moderate / greatly stressed

12. Is your problem affecting your ability to work or perform daily activities? No effect / some effect / greatly effected

13. If it is affecting your daily living, what areas are affected? sleeping / working / exercise / playing / standing

14. What time of day is most painful: morning / afternoon / evening / night time

15. Where in your body do you carry your stress? Head / Neck / Shoulders / Mid Back / Low back / Abdomen

16. What tools, activities or therapies have you used to reduce your stress? _____

17. Why do you think your body failed to heal itself this time? _____

18. What bad habits do you need to release? _____

19. Do you know why your brain and nerve system are called the Master Control System? Yes / No / Unsure

20. How many hours of sleep do you get each night? ____ Do you have trouble sleeping or falling to sleep? Yes / No / Some

21. What is your level of commitment to yourself, your life and wellbeing? high / medium / low

22. Are you willing to invest time, money and energy in taking better care of your health at this time? _____

23. What are the three most significant emotional traumas in your life? _____

_____

List other doctors consulted for present complaints and injuries:

Name: _____ Kind of doctor? _____ When? _____

Diagnosis: _____ Treatment: MRI /X-rays Date: _____

How long did you see the doctor? _____ How frequently? _____

Treatment Success: Good / Not Good / Okay / Other: _____

Present family doctor: _____ Last exam date: _____ Reason for visit: _____

What surgeries and Date have you had? _____ Outcome results: Good / Not Good

List history of accidents and falls (auto, work, home, leisure, sports, other): What / When / Treatments / Results:

_____

_____

List broken bones and Date of Fracture: _____

List Medications and Dosage/Supplements that you currently take: _____

Assignment of Benefits: I hereby irrevocably instruct and direct my insurance company to pay JESTER FAMILY CHIROPRACTIC, PC directly. For the professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any health information pertinent to my case to any insurance company, Health Care Financing Administration, or its agents, or attorney involved in this case. I authorize the doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf. I understand all the information on this form and I answered it true and correct to the best of my ability.

_____

Signature Print Name Date