Patient Information Sheet

Patient:

Last Name:_____ First Name:_____ Middle: _____

Gender: M / F Date of Birth:____/____/____ Age:____ SSN: _____

Home Address:_____ Apt. #:_____

City: _____ State:_____ Zip: _____

Home #:_____ Work #:_____ Cell #:_____

Employer Name: _____

Employer City:_____ State:_____

Spouse:

Last Name:_____ First Name:_____ Middle: _____

Employer Name:_____ Work #: _____

Date of Birth:____/____/____ SSN:_____

Emergency Contact (closest relative or friend that does not live in your house)**:**

Last Name:_____ First Name:_____ Middle: _____

Home #:_____ Work #:_____ Cell #:_____

Relation to patient: _____

Financially Responsible Party (other than patient or spouse)**:**

Last Name:_____ First Name:_____ Middle: _____

Home Address:_____ Apt. #:_____

City: _____ State:_____ Zip: _____

Home #:_____ Work #:_____ Cell #:_____

Date of Birth:____/____/____ SSN:_____

Employer Name, City & State: _____

Relation to patient: _____

Authorization to Treat:

I hereby authorize Dr. Darrell L. Day to treat my condition as he deems appropriate, through manipulation and therapy. Dr. Day will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

X _____

Signature (patient or responsible party) Today's Date

X _____

Witness

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and possibly of being accepted for care. Please enter 1 (never), 2 (Occasionally), 3 (Presently) in front of the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

General Symptoms

__ Headache
__ Fever
__ Chills
__ Night Sweats
__ Fainting
__ Dizziness
__ Convulsions
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Loss of Weight
__ Numbness or Pain in arms/legs/hands
__ Allergy (Wheat)
__ Wheezing
__ Neuralgia

Gastro-Intestinal

__ Poor Appetite
__ Poor Digestion
__ Excessive Hunger
__ Belching or Gas
__ Nausea
__ Vomiting
__ Vomiting Blood
__ Pain Over Stomach
__ Constipation
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids
__ Liver Trouble
__ Jaundices
__ Gall Bladder Trouble

Eye Ear Nose Throat

__ Poor Vision
__ Crossed Eyes
__ Pain in Eyes
__ Deafness
__ Earache
__ Ear Noises
__ Ear Discharges
__ Nasal Obstruction
__ Nose Bleeds
__ Sore Throat
__ Hoarseness
__ Hay Fever
__ Asthma
__ Frequent Colds
__ Tonsillitis
__ Sinus Trouble
__ Enlarged Thyroid

Respiratory

__ Chronic Cough
__ Spitting Blood
__ Spitting Phlegm
__ Chest Pain
__ Difficulty Breathing

Genito – Urinary

__ Frequent Urination
__ Painful Urination
__ Blood in Urine
__ Kidney Infection
__ Bed Wetting
__ Inability to Control Urine
__ Prostate Trouble

Muscle & Joints

__ Weakness
__ Twitching
__ Stiff Neck
__ Backache
__ Swollen Joints
__ Tremors
__ Foot Troubles
__ Painful Tail Bone
__ Pain Between Shoulders
__ Hernia
__ Spinal Curvature

Cardio-Vascular

__ Rapid Heart
__ Slow Heart
__ High Blood Pressure
__ Low Blood Pressure
__ Pain Over Heart
__ Prev. Heart Trouble
__ Swelling of Ankles
__ Poor Circulation
__ Varicose veins
__ Strokes

Skin or Allergies

__ Skin Eruptions
__ Itching
__ Bruising Easily
__ Dryness
__ Boils
__ Sensitive Skin
__ Hives or Allergy
__ Eczema
__ Medicines

For Women Only

__ Painful Periods
__ Excessive Flow
__ Irregular Cycles
__ Hot Flashes
__ Cramps or Backache
__ Miscarriage
__ Vaginal Discharge
__ Pregnant at this time
__ Last Pap

By Who:_____

Other:_____

_____

Habits

__ Smoking __pks/day__
__ Drinking __Alcohol__
__ Coffee __Cps/day__

Exercise: None Moderate Daily

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	__	__	__	__	__
Father	__	__	__	__	__
Brother No. of ____	__	__	__	__	__
Sister No. of ____	__	__	__	__	__

Have you had any of the following diseases?

__ Appendicitis __ Anemia __ Heart Disease __ Arthritis __ Pneumonia
__ Measles __ Goiter __ Epilepsy __ Rheumatic Fever __ Mumps
__ Influenza __ Polio __ Chicken Pox __ Pleurisy __ Cancer
__ Lumbago __ Tuberculosis __ Diabetes __ Alcoholism __ Eczema
__ Whooping Cough __ Venereal infection

Past Health History

Please check all that apply:

☐ Appendectomy / please indicate year:_____

☐ Tonsillectomy / year: _____

☐ Gall Bladder / year: _____

☐ Hernia / year: _____

☐ Back Surgery / year: _____ / Describe: _____

☐ Broken Bones / year(s): _____ / Describe: _____

_____

☐ Other / year(s): _____ / Describe: _____

_____

☐ Major Accidents or falls: _____

_____

☐ Other Hospitalizations: _____

_____

Previous Chiropractic Care (please circle one): yes / no

Name of Previous Chiropractor: _____

City and State (if other than Columbus, IN): _____

Date of Last Chiropractic Visit (if known): _____

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. Day will weigh your needs and desires when recommending your treatment program.

Consent

I hereby state that by signing this Consent I acknowledge and agree as follows:

1. Day Chiropractic Clinic (hereinafter referred to as "the Practice") has provided its Privacy Notice to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: (a) a postcard mailed to me at the address provided by me; (b) telephoning my home, work and/or cell phone and leaving a message on my answering machine, voice mail or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my agreement to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I acknowledge that I have viewed and/or received a copy of the Practice's Privacy Notice that has an effective date of April 14, 2003, and that I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Signature (Patient/Custodial Parent/Legal Guardian/Responsible Party) Date

_____

Witness

Authorization to Release Information

Patient's Full Name: _____

I hereby authorize Day Chiropractic Clinic to release any and all medical information concerning injuries, disabilities and physical conditions, including all medical records and x-rays, to any insurance company, adjuster or attorney that will assist in the reimbursement of medical expenses for the patient listed above.

I hereby state and agree that a photocopy of this authorization shall be considered as valid and binding on all parties involved as the original.

X _____ _____

Signature (Patient/Parent/Legal Guardian/Responsible Party) Date

X _____

Witness

Chiropractic Boosts Brain-Body Coordination

- article submitted by the Summit County Chiropractors and printed in the Summit Daily News

The brain is the master control system for the entire body. It sends and receives a complicate frequency of signals with the body that dictate the function of the body. When there is interference in this neurological feedback loop, it alters the environment the brain perceives itself to be in; this consequently changes the adaptation process the brain orchestrates throughout the body. Chiropractic adjustments have been shown to enhance the sensorimotor integration of the brain with the body.

Many experts have hypothesized that increased stress cycles in the body produce the environment for disease and eventually disease within the body. Stress can come from a variety of sources in the mental/emotional form, chemical form, and physical realm. When the body is under increased stress it responds by increasing its sympathetic tone. This means the body shuts itself into "fight or flight" survival based mode by altering cardiovascular and endocrine function to get itself ready for dynamic activity.

Increased sympathetic tone causes a release of stress hormones such as adrenalin, epinephrine, and cortisol. This is the same response we get when we are anxious or exercising. This is okay if it is for a short period of time; however, when the stress lasts longer than expected it exhausts the body and causes a state of disease to manifest.

When the brain sends information to the organs, muscles, and tissues of the body, this is called efferent neurological flow. In return, the afferent flow of information includes all the messages sent to the brain from skin, muscle, joint, and organ receptors. This afferent/efferent neurological loop is how the body is able to respond and adapt appropriately to its environment.

The ramifications of increased stress hormones in the body include overworked adrenal glands, lowered immunity, decreased digestive functions, fatigue, and blood pressure disturbances. Increased cortisol levels also cause ligament laxity by stripping critical proteins from the tendon and ligament structures. This causes joint weakness throughout the body, including the spine and extremities, making them much more susceptible to injury.

Subluxation is a term used to describe mechanical compression and irritation to spinal joints and nerves. Subluxation scrambles the neurological feedback loop by causing altered rhythms of neurological flow. Subluxations are caused by trauma, poor posture, or increased chemical and emotional stresses.

Subluxations are a physical stress on the body and therefore increase the sympathetic tone, so the body shunts its energy toward the fight or flight system. If the subluxation(s) are not corrected they continue to produce this increased stress response. This increases cortisol and causes greater joint and ligament laxity in the spine and extremities making them more susceptible to injury. Additionally, increased long-term stress on the body greatly accelerates the degenerative processes of the spine and joints leading to osteoarthritis.

Chiropractic adjustments have been shown to normalize spinal afferent/efferent processes to their proper resting tone. This is like hitting the reset button on the computer when it is malfunctioning. The computer is allowed to pause and reprocess itself. Chiropractic adjustments stop the stress response and restore normal hormonal and cardiovascular function to the body. This allows the body to reset itself and begin healing the damage that was done in the body due to chronic stress cycles.

Research performed by Taylor and Murphy demonstrated that chiropractic adjustments enhanced sensorimotor integration, the body's ability to sense where it is in space and effectively coordinate complex movement patterns. This improves function in both the brain and the body. Improved spatial intelligence translates into better physical and mental balance, coordination, and mobility. Chiropractic adjustments make you think and move with better speed, skill, and finesse.

DAY CHIROPRACTIC CLINIC

FINANCIAL AGREEMENT/CONDITION OF SERVICES

1. I agree, whether I sign as Patient, parent, guardian, agent, or as responsible party, that in consideration for the services to be rendered to the Patient by Day Chiropractic Clinic, its employees, agents, successors and/or assigns, I hereby individually obligate myself to pay the account of Day Chiropractic Clinic, their successors, agents or assigns, and any and all other healthcare providers associated with or contracted by Day Chiropractic Clinic who perform services at the request of Day Chiropractic Clinic on or for my behalf, and all of whom provide treatment, services, products or clinical oversight to me or any other person to whom I am contractually or legally responsible as evidenced by my signature herein below.
2. I agree that if any or all of this account is submitted to Medicare, Medicaid or to a third-party insurance provider, that should Medicare, Medicaid or the third-party insurance provider fail to pay any or all of the account balance, I shall be responsible for payment of the account.
3. I agree and acknowledge that should Day Chiropractic Clinic gratuitously undertake to submit this account for payment to Medicare, Medicaid or to a third-party insurance provider, that I shall remain solely responsible for monitoring and ensuring that the claim is properly submitted to the correct insurance provider(s). Nothing Day Chiropractic Clinic undertakes to do for the undersigned in the submission of this account to Medicare, Medicaid or to a third-party insurance provider shall relieve me of the responsibility for monitoring and ensuring that the claim for insurance benefits is properly submitted to the proper insurance provider(s). I acknowledge that it is my sole responsibility to ensure that the proper insurance information is provided to Day Chiropractic Clinic and agree to check all account documents in a timely fashion to ensure that the proper insurance information is on all account billing documents.
4. I agree to pay all bills submitted to me and/or resulting from services provided by Day Chiropractic Clinic to Patient, regardless of whether or not insurance was billed, not billed, or I believed that an insurance carrier and or Medicare or Medicaid was/is responsible for the payment of the bill.
5. I agree to provide Day Chiropractic Clinic with my current telephone number and address and insurance information within 5 days of any change in my address, telephone number or insurance information from today's date up to and including the date that this account is paid in full.
6. If Patient receives payment from an insurance carrier for services that were provided by Day Chiropractic Clinic, I will bring the check with the "Explanation of Benefits" into Day Chiropractic Clinic **within one week of receipt** and endorse it over to "Day Chiropractic Clinic". **Failure to do this may result in collection action and/or possible dismissal from care.**
7. Should the account be referred for collection, I agree to pay any and all reasonable attorney's fees not to exceed Thirty-three percent (33%) of the balance sought, in addition to court costs and reasonable collection expenses and/or charges. Reasonable attorney fees shall include, but not be limited to, any and all attorney fees charged in preparing, filing and obtaining a judgment against me, in addition to attorney fees charged in collecting upon a judgment by way of proceedings supplemental, garnishment or any other reasonable post-judgment collection method.

8. I hereby agree and stipulate that reasonable attorney fees shall be based upon a percentage of the total debt or upon the actual time, expenses and costs expended, all at the discretion of Day Chiropractic Clinic, Collection Agency and/or Attorney.
9. I hereby agree and stipulate that reasonable collection expenses and/or charges include, but are not limited to, the fees charged to Day Chiropractic Clinic by a collection agency, whether such fees are based upon a percentage of the actual debt or the actual time, expense and costs expended by a collection agency in their attempts to collect the debt.
10. I hereby agree that all delinquent accounts may bear a prejudgment interest rate of Ten Percent (10%).
11. If the undersigned is also the patient, I agree that any and all medical information related to my treatment and care may be entered into evidence in court if necessary to collect on this account and I hereby waive any and all Federal and State laws/rights I may have concerning the same, including any and all rights I may have under the Health Information Portability and Accountability Act of 1996, as codified at 42 USC §1320d ("HIPAA"), the Health Information Technology Act of 2009, as codified at 42 USCA prec. §17901 ("HITECH"), and any current and future regulations promulgated under HIPAA or HITECH.
12. I agree to pay a $20 fee for all returned checks which sum shall be added to the account balance. I acknowledge that if a collection suit is filed in court to collect this $20 fee, the Court may require me to pay three times (treble damages) the amount owed for a dishonored check, in addition to attorney fees.
13. I agree that upon receipt of the original bill from the Day Chiropractic Clinic, if I do not object to the charges contained therein within Forty-five (45) days, I shall be considered to have impliedly agreed that such charges and/or debts are accurate and correct.
14. If Patient misses an appointment without calling to cancel, Day Chiropractic Clinic reserves the right to charge Patient for an office visit ($40.00). This charge will NOT be billed to Patient's insurance carrier, and Patient will be responsible for paying the charge in full.
15. If any provision of this Agreement, or any portion thereof, is held to be invalid and/or unenforceable, then the remainder of this Agreement shall nevertheless remain in full force and effect. Further, a Court may modify the provision of the Agreement, or any portion thereof, which is held to be invalid and/or unenforceable to make it comply with the law of the State of Indiana.

I understand the implications of the agreements I have made herein. I have read the provisions of this Financial Agreement/Condition of Services, including, but not limited to the provision regarding missed appointments, and hereby agree to abide by and be bound to all of the provisions contained herein.

_____ _____

Signature (Patient/Custodial Parent/Legal Guardian/Responsible Party) Date

_____

Printed Name