Confidential Patient Information (Please Print)

Date_____

Personal Information

Dr./Mr./Mrs./Ms./Miss _____
Last Name First Name Middle Initial Nick Name

_____
Address City State Zip Code

Cell Phone _____ Home Phone _____

E-mail _____ (Will not be shared)

Social Security No. _____ Date of Birth _____

Occupation _____ Employer _____

Person to contact in an emergency _____ Phone _____

How did you hear about us? _____
(Please be specific, so we can thank them for their referral!)

Responsible Party

Name of person responsible for payment of this account _____

Relationship to patient _____ Phone _____

_____
Address (if different than patient address) City State Zip Code

May we contact this person for account/payment information? Y / N

Insurance Information

Name of Insured _____ D.O.B. of Insured _____
Insured's Relationship to the Patient _____
Insurance Company _____
Policy No./ID No. _____ Group No. _____
Insured's Address (if different than patient address) _____

Symptoms

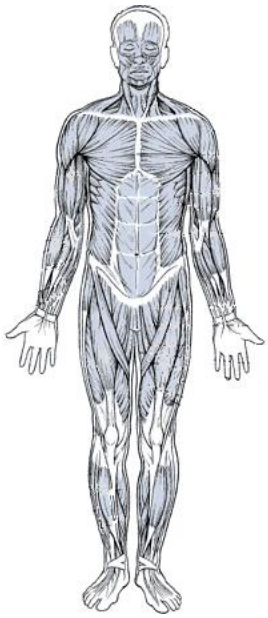
1. What is your **number one** problem or the **one area** of greatest pain? _____
   _____
2. Please rate the level of this pain on the following scale: **0 = no pain, 10 = severe pain or the worst pain**. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.
   0 1 2 3 4 5 6 7 8 9 10
3. When did this problem/pain begin? _____ Gradual onset _____ Sudden onset _____
4. What do you think caused this problem? _____
5. How often do you experience the pain?
   ___ 25% of the day ___ 50% of the day ___75% of the day ___100% of the day
6. How does the pain effect your daily activities?
   ___ It does not affect my daily activities ___I have had to stop doing certain activities
   ___ I have had to change how I do things ___I am unable to perform daily activities
7. What **increases** your pain? _____

8. What **decreases** your pain? _____
9. Have you ever experienced this problem before? ___ Yes ___ No When? _____
10. List any other complaints currently bothering you and rate your pain level for each.

_____ 0 1 2 3 4 5 6 7 8 9 10

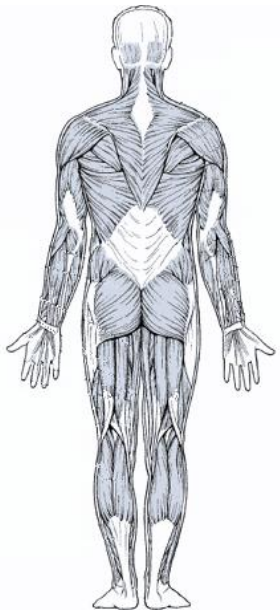
_____ 0 1 2 3 4 5 6 7 8 9 10

Are you pregnant? YES NO _____
Initials



Pain Diagram

P – Pain
T – Tingling
N – Numbness
B – Burning
S – Stiffness



11. Please provide a brief description of your past health history.

_____
_____
_____
_____
_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be hazardous to my health. I authorize this office to perform an examination and recommended treatment at this time and release any information including the diagnosis and records of any examination or treatment rendered to me or my child during the period of such chiropractic care to third party payers. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____
(Signature of parent/guardian if the patient is a minor)

Nichols Chiropractic, PA

Nichols Chiropractic may need to use my name, address, phone number, and clinical records to contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest. If this contact is made by phone and there is no answer, a message will be left on the answering service or with the person left responsible. I understand that I am giving Nichols Chiropractic the authorization to contact me with these reminders and information.

My signature on this form restricts the individuals or organizations to which my health care information is released: 1) individuals involved in my care or payment for my care; 2) health oversight authorized by law (activities necessary for government to monitor health care systems such as audits, inspections, etc); 3) national security; 4) public health risks; and 5) court order.

I understand information that Nichols Chiropractic will use or disclose based on the authorization I am giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

I understand in the case that I am required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I understand I have the right to refuse to give Nichols Chiropractic this authorization. I understand if I choose not to give Nichols Chiropractic authorization through signing this document, services will not be provided. I may inspect or copy the information that Nichols Chiropractic will use to contact me with appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of June 20, 2005 and will expire seven years after the date in which I last received services from Nichols Chiropractic.

I authorize Nichols Chiropractic to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form at my request.

I give my consent to the performance of an examination, conservative chiropractic treatment, and physical medicine modalities to the joints and associated soft tissues of the body. This may include physical therapies considered investigational by my insurance provider and not cleared by the FDA. Such physical therapies include electric muscle stimulation, herb formulary, and natural supplementation. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Patient Signature_____ Date_____

This office accepts assignment on most insurance. Your signature on file will be effective for one year past your last date of service. The co-pay, co-insurance, and deductible required by your insurance policy are due at the time of services rendered. Insurance benefits are a contract between the patient and the insurance company. Insurance benefit information obtained by Nichols Chiropractic from the patient's insurance provider is an estimate based upon the insurance provider's quote of benefits. Discrepancies in assumed benefits -vs- quoted benefits should be resolved directly between the patient and the insurance provider.

Insurance Signature on File

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits to either myself or to the party who accepts assignment.

I authorize payment of medical benefits to Nichols Chiropractic, PA for services rendered.

Patient Signature_____ Date_____

Informed Consent for Chiropractic Care

Patient Name:_____

Please read this entire document prior to signing. It is important to understand the information contained in this document before receiving chiropractic treatment. Please ask questions before signing if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. The provider may use their hands or a mechanical instrument upon the body in such a way as to move the joints. That may cause an audible "pop" or "click," much like the experience when "cracking" the knuckles. The patient may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, I am consenting to the following procedures: spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, basic neurological testing, radiographic studies, and therapeutic modalities (EMS, ultrasound, hot/cold therapy, iTrac, etc.).

The Material Risks Inherent in Chiropractic Manipulation

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fracture, disc injuries, dislocations, muscle strains/sprains, cervical myelopathy, and cost-vertebral 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 provider will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to attention, it is my responsibility to inform the provider prior to treatment.

The Probably of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check for during the taking of your history and during examination and/or x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment alternatives may include but are not limited to:

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

I understand by choosing any of the above noted "other treatment" options, there are risks and benefits of such options that should be discussed with my primary care 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.

Nichols Chiropractic, PA reserves the right to change or modify these terms and conditions at any time.

I have read or have had read to me the above explanation of the chiropractic manipulation and related treatment. I have discussed it with the provider and have had my questions answered to my satisfaction. By signing below I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended.

_____ **Date:** _____

Patient Signature

_____

Patient/Guardian Signature (if patient is a minor)

Nichols Chiropractic, PA

E-mail and Text (SMS) Messaging Informed Consent

Nichols Chiropractic may communicate with the patient through e-mail or text message. I am aware that by communicating via e-mail or text message, there are various confidentiality risks and other issues that may arise.

I understand all e-mail messages sent over the internet that are not encrypted are not secure and may be seen by others. I understand my e-mail communications with Nichols Chiropractic are not encrypted; thus, neither Nichols Chiropractic nor the provider can guarantee the confidentiality and security of any information sent to them or that they send out. Further, I understand text messages are less secure than e-mail messages and the same conditions apply.

I understand sending personal information via e-mail or text message is not recommended. This includes information concerning current or past symptoms, conditions, treatment, or identifying information such as social security numbers and insurance documentation.

I understand Nichols Chiropractic will limit text messages to brief notifications regarding scheduling.

I understand Nichols Chiropractic may e-mail me information regarding my treatment. I consent to receive such information via e-mail.

I understand e-mail and text messaging should not be used for urgent or sensitive matters as technical or other factors may prevent a timely response. I understand if I use e-mail or text messaging to make or request scheduling changes it is my responsibility to confirm that Nichols Chiropractic has received my communication more than 24 hours before the appointment time being changed. If I believe a response is necessary within 48 hours, I will not use e-mail or text messaging, but will call Nichols Chiropractic. If I do not receive a response to an e-mail or text message within two working days, I understand that I should call Nichols Chiropractic.

I understand e-mail and text messaging communications may be made part of my permanent medical record and will be accessible to anyone given access to those records. I understand I may withdraw permission for Nichols Chiropractic to communicate with me via e-mail or text messaging by notifying them in person.

_____ _____

Patient Name Printed Patient Signature

_____

Parent/Guardian Signature (if patient is a minor)

_____

Date