chiropractic profile & release form *Please complete in black ink.

village health wellness spa

Patient Information

First Name _____ M.I. _____ Last Name _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email _____ Sex ☐ M ☐ F Age _____ Birthdate _____ /_____ /_____
Month Day Year

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Occupation _____ Employer _____

Patient SS# (optional) _____ Spouse's Name _____

Emergency Contact _____ Emergency Contact Phone _____

How did you hear about us? _____ Email me monthly exclusive spa specials ☐ Yes ☐ No

Height ____ Ft. ____ In. **Weight** _____ Lbs.

Dominant Hand (Check all that apply)
☐ Right ☐ Left ☐ Ambidextrous

Sleeping Position
(Check all that apply)
☐ Back ☐ Stomach
☐ Right Side ☐ Left Side

Exercise
(Check all that apply)
☐ None ☐ Moderate
☐ Daily ☐ Heavy

Work Activity
(Check all that apply)
☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor

Patient Condition

Reason for Visit _____

Has this condition been diagnosed by a physician or other healthcare provider? ☐ Yes ☐ No

If yes, diagnoses _____

Have you had any previous treatment for this condition? ☐ **Yes** ☐ **No** If yes, describe _____

Did these treatments help? ☐ Yes ☐ Somewhat ☐ Not Much ☐ Not At All

Are you currently being treated for this condition by anyone else? ☐ **Yes** ☐ **No** If yes, describe _____

Are these treatments helping? ☐ Yes ☐ Somewhat ☐ Not Much ☐ Not At All

How does this condition affect you? _____

Is this condition due to an accident? ☐ Yes ☐ No If Yes, type: ☐ Auto ☐ Work ☐ Other _____ Date: _____

When did this condition and/or your symptoms first appear? _____

Please answer the following questions if you have pain:

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain (0=no pain to 10=severe pain) _____

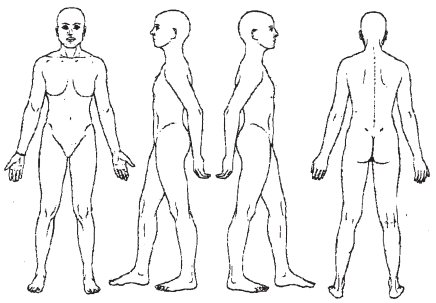
Type of pain: ☐ Sharp ☐ Burning ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Dull
☐ Tingling ☐ Stabbing ☐ Shooting ☐ Stiffness ☐ Other _____

How often do you have this pain? _____

Describe your pain: ☐ Constant ☐ Comes and Goes ☐ Other _____

Activities/Movements painful to perform: ☐ Sitting ☐ Standing ☐ Lying Down
☐ Walking ☐ Bending ☐ Other _____

Mark an X on any area(s) where you have pain, numbness and/or tingling.



front left side right side back

Health History

Indicate if you *currently have* or *have ever had* any of the following:

AIDS/HIV	☐ Yes	☐ No	Fracture	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Alcohol/Drug Dependency	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No
Allergies/Sinus	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Head/Neck Injury	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Herniated/Bulging Disc	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Atherosclerosis	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	High/Low Blood Pressure	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Blood Clot	☐ Yes	☐ No	Joint Dislocation	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Joint Surgery	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Spinal Fracture	☐ Yes	☐ No
Bursitis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Spinal Surgery	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Low Back Pain	☐ Yes	☐ No	Sprain/Strain	☐ Yes	☐ No
Carpal Tunnel Syndrome	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No	Tendonitis	☐ Yes	☐ No
Decreased Sensation	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Tennis/Golfer's Elbow	☐ Yes	☐ No
Degenerative Disc	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	TMJ	☐ Yes	☐ No
Dizziness/Vertigo	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Earache	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Neck Pain/Stiffness	☐ Yes	☐ No	Tumor/Growth	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Uneven Leg Length	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss/Gain	☐ Yes	☐ No

☐ Other _____

Describe/explain any treatment(s) you have had or are currently receiving for any of the conditions checked 'Yes' above. _____

_____

List all past/present injuries, dislocations, broken bones and/or surgeries with date.

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Habits
Check all that apply.

- ☐ Caffeine
- ☐ Alcohol
- ☐ Drug
- ☐ Smoking
- ☐ High Stress

Date of Last
List month/year of most recent.

Physical Exam _____

Spinal X-Ray _____

MRI _____

CT _____

Bone Scan _____

Medications & Vitamins/Herbs
List all medications, vitamins and/or herbs you are currently taking & reason.

_____

_____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been presented with a copy of the Village Health Georgia, PC 'Notice of Privacy Practices'. This notice describes how Village Health Georgia, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights that I have regarding my protected health information.

_____ _____ _____

Signature of Patient, Guardian or Personal Representative | Relationship to Patient | Date

Informed Consent & Release

The nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a click or a pop such as the noise when a knuckle is cracked and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, traction and stretches may be utilized.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints or injury to the intervertebral disks, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. The risks of complications due to chiropractic treatment have been described as rare, about as often as complications from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be further reduces by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

I have read the above information, have fully evaluated the risks and benefits of being treated and hereby give my full consent for examination and chiropractic treatment(s) to be performed on me by Village Health Georgia, PC (dba Village Health Wellness Spa). I further acknowledge and state that each and every visit or appointment I have with Village Health Georgia, PC, at any location, subsequent to this date, shall constitute a continuation, revival, and renewal of this release.

_____ _____ _____

Signature of Patient, Guardian or Personal Representative | Relationship to Patient | Date

Patient Financial Agreement

Village Health Wellness Spa is dedicated to providing the best possible service in a cost effective manner. In order to accomplish this, we depend upon prompt payment for the services we provide and have adopted the following policies:

Payment Due at Time of Service
I acknowledge that payment is due at the time of service. I agree that in return for the services provided to the patient by Village Health Wellness Spa, I will pay my account at the time service is rendered. I consent that I am responsible for any and all charges assigned to me by my insurance plan including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. All past due balances are due and payable at the time of service.

Patient Responsibility
I understand that filing a claim with my insurance plan does not relieve me from my responsibility for the payment of all charges. If no payment is received from my insurance plan, the full balance of my account will be my responsibility. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I accept financial responsibility for any services which are determined by my insurance plan not to be covered and/or denied. I understand and agree that if my account is delinquent, I may be turned over to a collection agency and responsible for collection expenses.

Insurance Assignment & Release of Information
I hereby authorize Village Health Wellness Spa to release all information necessary for claim reimbursement from insurance companies to who claims may be submitted and/or to secure the payment of benefits. I assign payment of insurance benefits to Village Health Wellness Spa for services rendered.

Blue Cross Blue Shield Payment Acknowledgement
In some cases, Blue Cross Blue Shield remits payment checks directly to the patient rather than the chiropractic office at which services were rendered. If this occurs, I understand that I am responsible for forwarding these payments to Village Health. I understand and agree that if my account is delinquent for these payments, I may be turned over to a collection agency and responsible for collection expenses.

Self-Pay Accounts
Self-pay accounts are patients who are covered by insurance plans that the practice does not participate in, or patients without an insurance card on file or at the time of service. I agree that I am individually obligated to pay the full charges at the time of service. If a group or organization discount is received for service(s) and I am not enrolled or a member of that organization at the time of service, I will be responsible for the difference between the discounted charge and the full charge.

Minors
Minors (patients under the age of 18) must have a signed consent for treatment by a parent or legal guardian on file. Minors must be accompanied by a parent or legal guardian in order to be treated. The parent(s) or guardian(s) accompanying a minor are responsible for payment.

Late Fee
Past due accounts and balances not paid by the due date on the statement are subject to a late fee of $25.00.

Returned Check Fee
Any payment by check returned by the bank will be subject to a returned check fee of $35.00.

By signing below, I acknowledge that I have read, understand and agree to the above Financial Agreement.

_____ _____ _____

Signature of Patient, Guardian or Personal Representative | Relationship to Patient | Date