FAMILY CHIROPRACTIC PLUS

Dr. Joy McClenny
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NEW PATIENT INFORMATION

Name:		Date:
Address:		City/State/Zip:
Home #:	Work #:	Cell #:
Birth Date:	Age:	Social Security #:
Marital Status: ❑ M ❑ D ❑ S ❑ W		Email:
Your Employer:		Occupation:
Spouse's Name:		Spouse's Employer:
Children's Names and Ages:		
Favorite Hobbies or Interests:		
Method of Payment for First Visit:	Cash Check Credit Card	

Reasons for consulting our office: (please check or circle all that apply)

- ❑ Headaches
- ❑ Sinus Problems
- ❑ Difficulty sleeping
- ❑ Indigestion
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Other: _____
- ❑ Arm or Leg Pain
- ❑ Low Energy
- ❑ Low Immune function
- ❑ Ears Ringing
- ❑ Eye Problems
- ❑ Allergies
- ❑ Asthma
- ❑ Numbness in Leg
- ❑ Numbness in Arm
- ❑ Heartburn
- ❑ Fibromyalgia or MS
- ❑ Wellness

Have you ever seen a Chiropractor before? _____
Who may we thank for referring you?_____
Have you had same or similar problem(s) before? _____
If so, for how long? _____
Is this the result of an auto accident?_____ If so, when?_____
Father, mother, brother, sister, children with similar problems?_____ If so, who? _____
Other doctors you have seen for this problem?_____
Surgeries you have had: _____
Medications you currently take: _____
Is there any chance you are pregnant?_____
Have you ever been diagnosed with cancer?_____ If so, what kind? _____

Do you have health insurance?_____ Name of Company:_____

The above information is true and accurate to the best of my knowledge. I Clearly Understand and Agree that All Services Rendered to Me are Charged Directly to Me and that I Am Directly Responsible for Payment.

Patient or Guardian Signature:_____ Date:_____

Vertebral Subluxations Can Cause Symptoms

1. Which symptom or condition you have checked is the worst?
   _____
   _____

2. How long has it bothered you?
   _____
   _____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Is your pain sharp or dull?
   _____
   _____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Is your pain constant or occasional?
   _____
   _____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which one is harder for you?
   _____
   _____

6. Does this pain radiate into an extremity or stay in one area?
   _____
   _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X-Rays

Our x-ray services provided here at Family Chiropractic Plus are chiropractic specific only. If you should ever need a copy put on a thumb drive the charge will be calculated depending upon what views were taken.

If the Doctor of Chiropractic finds it's necessary to have your x-rays reviewed by a third-party Radiologist, the cost will be $60.00.

_____ _____

(Signature) (Date)

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Dr. McClenny has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____

(Signature) (Date)

Text Message and Email Reminders

We offer text message and email reminders to help keep our patients on time for all appointments. With our new company the setup is automatic with text message and email reminders. If you do not receive text message or email reminders, you will get an automatic call from our office also confirming your appointment. You do have the option to OPT out of the txt messages or feel free to let our front desk receptionist know. Also please remember that this is just a reminder, it is not a guarantee due to software malfunction. You are responsible to keep up with your own time and date of your pre-scheduled appointments.

Please be aware if you do miss more than 3 appointments you will not be allowed to pre-schedule an appointment. You will have to call the day of to make an appointment.

_____ _____

(Signature) (Date)

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

- We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your 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 have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature / Date	Date