

Reinhardt Chiropractic, LLC

GENERAL INFORMATION

- Please Print

Today's Date: ____/____/____

Patient's Full Name _____ **Date of Birth** ____/____/____

(PLEASE PRINT)

Address _____ **Care of** _____
(Parent or financially responsible person)

City _____ **State** _____ **Zip** _____

Phone (home) ____-____-____ **Phone (work)** ____-____-____ **ext.** ____ **Phone (Cell)** ____-____-____

Spouse's Name _____ **Spouse's Employer** _____

PLEASE CIRCLE ALL THAT APPLY-

Sex:	M	F	Married	Single	Social Security Number
			Widowed	Divorced	- -
Patient's Employer or School _____					
Address _____					
City _____		State _____		Zip _____	
Occupation: _____					
<i>Full time</i>		<i>Part time</i>		<u>STUDENT</u>	
<i>Not employed</i>		<i>Retired</i>		<i>Full time</i> <i>Part time</i> <i>Non-student</i>	

Who may we thank for referring you or how did you hear about us:

Your children's names are:

Email Address:-

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

<p><i>Primary Insurance Company Name</i></p> <hr/> <p><i>Phone #</i> _____</p> <p><i>Policy/ID#</i> _____</p> <p><i>1st Insured Name</i> _____</p> <p><i>Relation to You</i> _____ <i>Date of Birth</i> _____</p>	<p><i>Secondary Insurance Company Name</i></p> <hr/> <p><i>Phone #</i> _____</p> <p><i>Policy/ID#</i> _____</p> <p><i>1st Insured Name</i> _____</p> <p><i>Relation to You</i> _____ <i>Date of Birth</i> _____</p>
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Policies

I understand and agree that:

- **All first visit charges are payable when services are rendered.** The fee paid for x-rays, is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary at the expense of those who request them. I authorize Reinhardt Chiropractic, LLC to submit claims to my health insurance company for any services provided to me.
- Method of payment you plan to use to take care of today's charges? ~Cash ~Credit/Debit Card **(NO CHECKS ACCEPTED)**

I understand Reinhardt Chiropractic, LLC will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Reinhardt Chiropractic, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and I am personally responsible for payment. I further understand the cost of my chiropractic treatments and believe the charges to be reasonable and necessary expense. I certify that the information I give is true and understand that it is completely confidential. I also understand that if I suspend my care at this office, any outstanding charges for professional services will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees, if legal action becomes necessary to collect this account. I authorize Reinhardt Chiropractic, LLC. to obtain a credit report if deemed necessary.

Patient Signature _____ **Date** _____

Guardian Signature Authorizing Care _____ **Date** _____

In case of emergency, notify: _____ **Phone** _____

What is your MAJOR COMPLAINT:

How long have you had this condition? _____ *Date of Onset* _____
Have you lost workdays? YES / NO If yes, how many? _____
Have you had this similar condition before? YES NO If yes, when? _____
Was the injury, accident related? YES / NO Auto Accident / Work accident If yes, when? _____
Name other doctors you have seen for this condition: _____

PREVIOUS CHIROPRACTIC CARE? YES / NO Chiropractor's Name: _____
When was your last visit? _____
What was the reason for your initial visit? _____
What spinal maintenance programs were you given to follow to maximize the future stability of you spine?
_____ Did you follow it? _____ If not, why? _____
Why are you changing Chiropractors? _____

ANY SURGERIES, HOSPITALIZATIONS, AND SERIOUS ILLNESSES YOU HAVE HAD? (List Year in bracket):

List *all drugs* you now take, *amount and frequency taken*: _____
Alcoholic Beverages? Y / N Average Number of drinks / Week? _____
Do you Smoke? Y / N How many Packs / Day: _____
Drink Coffee? Y / N Cups / Day? _____ Do you Exercise? ____ None ____ Mild ____ Moderate ____ Strenuous
Known Allergies: _____

FAMILY HISTORY:

Has any one in your family have or had any illnesses/conditions that we should know about? (i.e. Heart Disease, Arthritis, Cancer, etc)

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?) _____
How do you expect to achieve these goals? _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

___ Temporary Relief (Help the symptoms but do not fix the cause of the problem.)
___ Maximum Correction (Correct the problem for maximum stability.)

ON A SCALE OF 1 - 10 (10 being the most, 1 being the least),

___ How Committed are you to being at your maximum health potential?
___ How important is it for your family to be at their health potential?
___ How Committed are you to preventing arthritis and maximizing your spinal stability?

WOULD YOU LIKE A FREE 30 MINUTE CONSULTATION WITH OUR NUTRITIONIST? YES NO

Please mark if you have had any of these symptoms in the past 12 months:

- ___ Fractured bones
- ___ Auto Accidents
 - ___ 0-1 yrs ago
 - ___ 1-5 yrs ago
 - ___ 5 yrs or more
- ___ Other accidents, falls
- ___ Arthritis
- ___ Diabetes
- ___ Skin problems
- ___ Cancer
- ___ Frequent colds, flu
- ___ Depressed
- ___ Irritable
- ___ Anemia
- ___ Allergies; please describe:

- ___ Under stress
- ___ Eating disorders
- ___ Trouble sleeping
- ___ Trouble concentrating
- ___ Learning disability
- ___ Mood Changes

- ___ Neck pain/Stiffness R L
- ___ Numbness/tingling, pain in arms, hands, fingers R L
- ___ Jaw pain or clicks (TMJD)
- ___ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
- ___ Shoulder pain R L
- ___ Dizziness
- ___ Ringing in ears R L
- ___ Hearing loss R L
- ___ Blurred or doubled vision
- ___ Upper back pain, stiffness
- ___ Mid back pain, stiffness
- ___ Lower back pain, stiffness
- ___ Pain with cough, sneeze
- ___ Hip pain R L
- ___ Headaches
- ___ Numbness, tingling, pain in buttocks, legs, feet, toes
- ___ Foot trouble R L

- ___ Difficulty Breathing
- ___ Chest pain, asthma
- ___ Heart problems
- ___ Stroke
- ___ High/low blood pressure
- ___ Varicose veins
- ___ Liver trouble
- ___ Gall bladder trouble
- ___ Digestive problems
- ___ Ulcers
- ___ Hemorrhoids
- ___ Migraines
- ___ Prostate problems
- ___ Impotence
- ___ Kidney trouble
- ___ Asthma
- ___ Menstrual problems (PMS)
- ___ Pregnant (NOW)
- ___ Heartburn
- ___ Bed wetting
- ___ Ear Infections
- ___ AIDS, HIV

Patient Name: _____ Date: _____

SYMPTOM ASSESSMENT
(To be filled out by the Patient)

MARK ON THIS BODY, USING THE APPROPRIATE SYMBOLS.
PLEASE MARK ALL AREAS USING THE DESCRIBED SENSATIONS
THAT YOU FEEL.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
XXXXXXXX XXXXXXXX	OOOOOO OOOOOO	 	+++++++ +++++++

Back
L
R
Front

What is your Pain level RIGHT NOW?

No Pain 2 3 4 5 6 7 8 9 10 Worst Pain

What is your TYPICAL or AVERAGE Pain level?

No Pain 2 3 4 5 6 7 8 9 10 Worst Pain

What is your Pain level at its BEST (How close to "0" does you pain get at its best?)

No Pain 2 3 4 5 6 7 8 9 10 Worst Pain

What is you Pain level at its WORST (How close to "10" does your pain get at its worst?)

No Pain 2 3 4 5 6 7 8 9 10 Worst Pain

Other Comments: _____

ATTENTION FEMALES

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his/her associates have my permission to perform X-Rays. I have been advised that X-Rays can be hazardous to an unborn child.

Date of Last Menstrual Period: _____

Patient / Guardian Signature

Date

NOTICE OF PRIVACY PRACTICE SUMMARY

I, _____, hereby consent and state my preference to have my physician, **Dr. Graham Reinhardt**, and other staff at **Reinhardt Chiropractic, LLC.**, to communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number _____

Email _____

Text _____

I give permission to contact me, relative to appointment reminders only, by the following methods: (check off the ones to agree to)

Phone message _____

Email messages _____

Text messages _____

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided for you.

Reinhardt Chiropractic, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and evaluate the quality of care you receive.

Reinhardt Chiropractic, LLC will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires to do so.

Reinhardt Chiropractic, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Reinhardt Chiropractic, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, at right to request restriction, report and retain a copy of your health record, request communication of your information by alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the office manager and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Reinhardt Chiropractic, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reason other than those listed above and permitted by law.

If you have any questions or concerns, please contact the office manager at (303) 955-4609

Amendment to the HIPAA Form: Patient Authorization regarding Chiropractic care being provided in an "open adjusting" environment.

Added: This includes signing in at the front desk where others may be able to view your signature.

Patient / Guardian Signature

Date

I authorize Reinhardt Chiropractic, LLC to release private medical information to or discuss my care with the following person(s). (Example: spouse, child, family physician, power-of-attorney, caretaker, family member, etc.)

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic Health Care seeks to restore health through natural means and without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The Success of Chiropractor's procedures often depends on environment, underlying causes, and the physical and spinal health of an individual. It is important to know what to expect from Chiropractic Health services.

ANALYSIS

A Chiropractor conducts a clinical analysis for the express purpose to determining whether there is evidence of Vertebral Subluxation Complex (VSC). When VSC is found, Chiropractic Adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractors are experts in chiropractic diagnosis, the Vertebral Subluxation Complex, they are not internal medical specialists. We do not offer to diagnose or treat any diseases or condition other than Vertebral Subluxation. However, if during the course of 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 another health care provider. 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 be expression of the body's innate wisdom. Our only method is specific adjusting to correct Vertebral Subluxation. Every Chiropractic patient should be mindful of their own symptoms and should secure other opinions if they have any concern as to the total nature of their condition. Your Chiropractor may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractor, gives the Doctor Permission and authority to care for the patient in the accordance with Chiropractic tests, diagnosis, and analysis. The Chiropractic Adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, will not give a chiropractic adjustment, or other health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractor provides a specialized non-duplication health care service. The Doctor of Chiropractic is licenses in a special practice and is available to work with other types of providers in you health care regime.

I hereby authorize and release the doctor and whom ever he may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I hereby authorize an office evaluation, examinations and X-Rays to be performed. Note that X-Rays will be solely responsible to the patient for cost and coverage. Should I choose to become a patient in this office, I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC since there are so many variables; it is difficult to predict the time schedule or efficiency of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally the results are less than expected, two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn we must admit that conditions which do not respond to chiropractic, may come under the control by or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. However, both have their place. The patient should discuss any questions or concerns with the Doctor before signing this statement or policy.

I HAVE READ THE FOREGOING AND UNDERSTAND IT.

Patient Signature: _____ **Date:** _____