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 Widowed Divorced	**Social Security Number** - -

Patient's Employer or School_____

Address_____

City _____ State_____ Zip _____

Occupation: _____ ***STUDENT***

Full time Part time Not employed Retired

Full time Part time Non-student

Gender Pronoun
(circle one): He / She / They

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

Primary Insurance Company Name	***Secondary Insurance Company Name***
*Phone #*_____	*Phone #*_____
Policy/ID# _____	*Policy/ID#* _____
1st Insured Name _____	1st Insured Name _____
Relation to You_____Date of Birth _____	Relation to You _____Date of Birth_____

Policies

I understand and agree that:

- **All first visit charges are payable when services are rendered.** 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 to 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 missed 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 anyone 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 CONSULTATION WITH OUR RECOMMENDED ACUPUNCTURIST? ☐ 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 R L
____Foot trouble R L

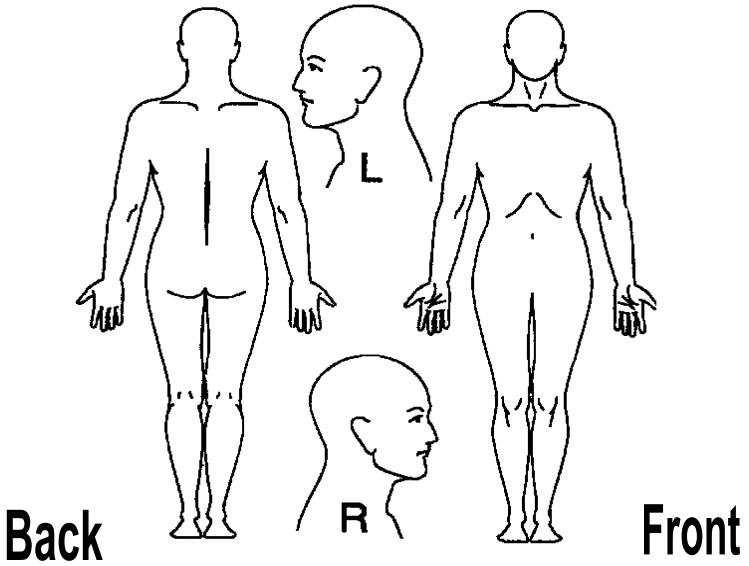
____Difficulty Breathing
____Chest pain
____Heart problems
____Stroke
____High/low blood pressure
____Varicose veins
____Liver trouble
____Gall bladder trouble
____Digestive problems
____Ulcers
____Hemorrhoids
____Migraines
____Prostate problems
____Impotence
____Kidney trouble
____Asthma
____Menstrual 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	::::::::::::::::::::	OOOOOO	IIIIIIIIIIIIIII	++++++++
XXXXXXXX	::::::::::::::::::::	OOOOOO	IIIIIIIIIIIIIII	++++++++



What is your Pain level RIGHT NOW?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

What is your TYPICAL or AVERAGE Pain level?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

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

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

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

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

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 us 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 you 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 traditional 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 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 determine whether there is evidence of any restrictions or misaligned spinal joints as known as a 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 and treatment, they are not internal medical specialists. Specific orthopedic and neurological examinations are performed to properly diagnose any subluxations and/or other diagnoses related to each patient. If during a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you on the next best steps. We do not alter any advice regarding treatment prescribed by others but will keep in mind all relevant past medical histories. 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 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 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/she 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 licensed in a special practice and is available to work with other types of providers in your health care regime. I hereby authorize and release the doctor and whomever 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 when medically necessary. Note that the patient may be solely responsible for the cost and coverage for various services that are not covered by insurance or some other third party. Should I choose to become a patient in this office, I authorize the release of any information necessary to process my insurance claims, assign benefits over to the clinic, and request payment directly to my physician.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the patient's symptoms. Since there are so many variables in each individual, it may be difficult to predict the time schedule or efficiency of chiropractic procedures and treatments. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally the results are less than expected, as 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.

CANCELLATION POLICY

All patients are responsible for keeping track of their scheduled appointments. In the event of a schedule change, we do require 24-hour notice. Any cancellations under 24-hour notice will be charged a cancellation fee for that visit. All scheduled massages require 24-hour cancellation notice. If no notice is given for a massage, the patient/ client will be subjected to a fee.

I HAVE READ THE FOREGOING AND UNDERSTAND IT.

Patient Signature: _____ **Date:** _____

REINHARDT
CHIROPRACTIC & WELLNESS

Payment Agreement

I understand and agree that I am financially responsible for payment for all services rendered at Reinhardt Chiropractic, LLC at the time of service.

I understand and agree that I may be billed by Reinhardt Chiropractic, LLC for services that were not covered by my insurance company.

I understand and agree that any insurance checks I receive are not reimbursements to me, but the percentage that my insurance covers for the services rendered at Reinhardt Chiropractic, LLC. I agree to bring in any checks I receive from my insurance to Reinhardt Chiropractic, LLC so they may apply them to my account.

Print Name: _____

Sign Name: _____

Date: _____

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