Fraser Valley Chiropractic, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

Dr. Jill M. Hutter D.C. 208 E. Eisenhower Dr. Fraser, CO 80442 P. (970) 363.7156 F. (303) 292.1244

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Consent Form To Chiropractic

Chiropractic focuses on the nervous system and spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures.

I, _____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanations to my questions. My signature below authorizes this procedure.

_____	_____	_____
Patient/Authorized Representative Signature	Relationship to Patient	Date

Practitioner Statement: The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

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Practitioner Signature _____ Practitioner Printed Name Jill M. Hutter, D.C. Date _____

WELCOME! PLEASE PRINT.

** Please allow our staff to photocopy your driver's license and all available insurance cards**

PATIENT INFORMATION:

Full Name_____ Gender: ☐**M** ☐**F** Age____ Birth Date_____
Address _____ City _____ State _____ Zip _____
Marital Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Separated** Number of Children: __
Social Security #: _____ Driver's License #: _____
Home Phone (_)_____ Work Phone (_)_____ Cell Phone (__)_____
What is the best number to contact you? ☐Home ☐Work ☐Cell E-mail _____
Employer _____ Occupation _____
Business Address_____ City _____ State _____ Zip _____
Whom may we thank for referring you? _____
Describe the major complaints that bring you to our office: _____
_____
Is your condition due to an accident? ☐ Yes ☐No Date of your accident: _____

EMERGENCY CONTACT:

Name _____ Home Phone (_____)_____
Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE:

Do you have health insurance? ☐Yes ☐No
Insurance Company _____ Member I.D. #: _____
Insurance Company Address _____ City_____ State ____ Zip _____
Group #: _____ Plan #: _____
Person Responsible for Account _____ Date of Birth _____
Relationship to Patient _____ Social Security #: _____
Spouse's Employer_____ Occupation_____
Spouse's Work Address _____ City _____ State_____ Zip _____
Insurance Company _____ Work Phone(__)_____
Insurance Company Address _____ City _____ State ____ Zip _____
Insurance Company Phone (___)_____ Member I.D. #: _____
Group #: _____ Plan #: _____

If you have secondary insurance, please submit a copy of your insurance card to our staff

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Please answer the questions below concerning you health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history will help us to determine appropriate care.

Review of Systems

1. Do you have skin, hair or nail problems? ☐Yes ☐No
2. Do you have nose and/ or sinus problems? ☐Yes ☐No
3. Do you have ear problems? ☐Yes ☐No
4. Do you have eye problems? ☐Yes ☐No
5. Do you have chest or lung problems? ☐Yes ☐No
6. Do you smoke? ☐Yes ☐No
7. Do you have heart and/ or blood vessel problems? ☐Yes ☐No
8. Do you have blood or nymph node problems? ☐Yes ☐No
9. Do you have digestive problems? ☐Yes ☐No
10. Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐Yes ☐No
11. Do you have urinary (including kidney or bladder) problems? ☐Yes ☐No
12. **Females**, have you had menstrual problems? ☐Yes ☐No
    Have you ever taken birth control pills? ☐Yes ☐No
    Is there any chance that you are currently pregnant? ☐Yes ☐No
    Do you have any breast problems? ☐Yes ☐No
13. Do you have any nervous system diseases and/ or mental health problems? ☐Yes ☐No
14. Do you have any gland and/or hormone problems? ☐Yes ☐No
15. Do you have allergy or immunity problems? ☐Yes ☐No
16. Do you have any muscle, tendon or ligament problems? ☐Yes ☐No
17. Do you have any bone or joint diseases (ex. Bone= osteoporosis, joint= arthritis)? ☐Yes ☐No

Past History

18. List any diseases which you have had in the past, including childhood diseases: _____

    _____

19. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc. _____

    _____

20. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, laceration, sprains, strains, dislocations, broken or cracked bones? ☐Yes ☐No

    _____

    _____

21. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):

    _____ Date_____

    _____ Date_____

    _____ Date_____

22. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐No

    _____

    _____

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(OVER PLEASE)

23. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking of take on an occasional basis:_____

_____

24. Your diet is: ☐Balanced ☐Fair ☐Poor ☐Excessive ☐Restricted

Family History

25. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?
☐Yes ☐No _____

Social History

26. In what position do you usually sleep, and how well? _____

_____

27. Do you exercise on a regular basis? ☐Yes ☐No How? _____
28. How do you spend your spare time (hobbies, etc.)? _____
29. Do you use: ☐Caffeine ☐Tobacco ☐Nicotine ☐Recreational Drugs ☐Alcohol
30. Please describe your work.
Type: ☐Professional ☐Physical Labor ☐Driver ☐Clerical ☐Factory ☐Homemaker

Physical Demands: ☐Heavy ☐Moderate ☐Mild ☐Sedentary

Stress Level: ☐High ☐Medium ☐Low

Additional Questions

31. Do you have problems with recurring headaches? ☐Yes ☐No _____
32. Are you losing weight without trying? ☐Yes ☐No _____
33. Does your pain wake you up at night? ☐Yes ☐No _____
34. Have you had a change in bowel or bladder habits? ☐Yes ☐No _____
35. Have you had a sore that doesn't heal? ☐Yes ☐No _____
36. Have you recently had any unusual bleeding or discharge? ☐Yes ☐No _____
37. Do you have a thickening/lump in the breast or elsewhere? ☐Yes ☐No _____
38. Do you have digestion or difficulty swallowing? ☐Yes ☐No _____
39. Have you had an obvious change in a wart or a mole? ☐Yes ☐No _____
40. Do you have a nagging cough or hoarseness? ☐Yes ☐No _____
41. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

_____

_____

_____

_____

42. Who is your:
Medical Doctor? _____

OB/GYN? _____

Dentist? _____

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I (we) agree to pay for the services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for the professional services rendered to me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case manager, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of a consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/ chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

I (we) understand that a service charge of $50.00 for missed appointments may occur if 2 hours prior notification of cancellation does not occur.

Patient's Signature_____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

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