Ideal
Posture & Spine
AFFILIATE OF THE WELLNESS WAY

New Patient Application - Wellness begins here

Full Name _____ SS# _____ Sex _____

DOB ___/___/___ Age ____ Cell Phone _____ E-mail_____

Address _____ City _____ State _____ Zip _____

Occupation _____ Marital Status _____ Spouse Name _____

Number of Children _____ Emergency contact _____ Emergency phone _____

Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?

_____

Science tells us your spine like your teeth need to be cared for regularly.
How often do you get adjusted by a chiropractor? ☐Frequently ☐only when you hurt ☐1 x monthly ☐never

When was your last complete spinal examination including x-rays?_____ ☐Never

Do you know if you have? ☐a spinal curvature ☐spinal arthritis ☐inherited spinal problem

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back as well as, loss of Nerve Health. Do you hear these sounds when you move your head or neck?
☐Yes ☐No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐Yes ☐No

Poor posture leads to poor health and early death. How would you rate your posture?
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months.
None 1 2 3 4 5 6 7 8 9 10 Intense

Please circle or list any health symptoms or health complaints you are experiencing

Neck pain L/R	Mid-back pain	Low-back pain.	Arm pain/Numbness L/R	Leg pain L/R
Heart Disease	Thyroid	Asthma	Cancer	Allergies
Headaches	Migraines	Constipation	Diabetes I/II	Menstrual pain
Leaky gut	Hormonal Imbalance			

Other: _____

Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

Medication	Dosage

Please list any surgeries you have had _____

Do You Smoke? ☐ Yes ☐ No

Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant? ☐ Yes ☐ No

Daily trauma, auto wreck(s), and work injuries can cause misalignment of vertebrae and serious spinal problems. When was your most recent injury at home? _____ Car accident? _____ Slip or fall?_____

Improper sleeping positions can cause spinal misalignment and spinal damage.
What sleeping position do you sleep in: ☐Back ☐Stomach ☐R Side ☐L Side

Rate your level of exercise in the last year: Never 1 2 3 4 5 6 7 8 9 10 Often

Please list vitamins/supplements you take:

Supplement	Dosage

If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely? ☐Yes ☐No

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian): _____ Date: _____

FINANCIAL POLICY

To help us meet all your healthcare needs, please read this form completely. If you have any questions or need assistance, please ask us and we will be happy to help. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

We do not currently bill to insurance. Some of the charges are reimbursed by insurance. For example chiropractic exams, x-rays, and manipulations (aka adjustments) coverage depends on your individual insurance policy. It is your responsibility (the patient's) to contact your insurance company to verify what chiropractic coverage you may have (out-of-network). We will provide a Superbill for submission to insurance. We do accept and bill Medicare for chiropractic adjustment only

Unless arrangements are made in advance between you and Ideal Posture and Spine, full payment is due at the time of service.

❑ The patient understands and agrees by his/her signature agrees upon the charges for professional services provided by Ideal Posture & Spine

❑ Although you are responsible for the entire balance at the time of service, it is our office policy to provide you with the necessary paperwork for reimbursement. We do require that you take care of the balance at the time of service.

❑ Our fees are considered as usual, customary and reasonable (UCR) fees within the Charleston metro area. Some insurance companies set their own (UCR) fees, which may not be the same as our fees.

❑ The patient further understands and agrees that if the balance due is not paid in full within 60 days from the date of service, there will be a billing charge of 1-1/2% per month or 18% per annum until the outstanding balance is paid in full.

❑ If the account is assigned to collections, the patient will be responsible for the entire account balance owed plus any collection and reasonable attorney fees.

❑ Functional medicine or nutrition services are not billable to insurance at this time.

❑ I understand that there is a 24 **business hour cancellation policy** for new patient, consultation, and adjustment appointments. Failure to comply with the cancellation policy may result in additional charges.

Patient/Guardian Signature_____ Date_____

Informed Consent

Nutritional Informed Consent According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me (or on the patient named below for who I am legally responsible)

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cold packs, muscle therapy, exercises, or traction therapy may also be used.

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

Probability of risks occurring: The risk of complications due to chiropractic treatment have been described as "rare", about as often as complications from ingesting a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million.

Other treatment options which you might have considered could include the following:

- *Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.*
- *Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.*
- *Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.*
- *Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. There is also a real probability of poor outcome.*

Risks of remaining untreated: *Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.*

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

Printed Name:_____ ***Signature:_____***

WITNESS: (required): _____ ***Doctor Signature:_____***

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in consent unless compelled to do so by legal authority. Further, you will be contacted by phone or mail in the event that a request for information is made.

FACILITY SET UP

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosures to others in the facility at the same time. If there is private information that you need to discuss, please request to do so in a private room.

YOUR RIGHTS

You may send us a written request to see or procure a copy of the information that we have about you, or to amend you personal information that you believe is incomplete or inaccurate. If the information was not originally from our office, we will refer you to the source, such as other doctors or hospitals.

You may request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances, may be prohibited by law.

You may request that we communicate with you about medical matters using reasonable alternative means or at an alternate address. You may receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

You have the right to inspect and have a copy of your medical information. There is no cost for the first copy and any copy thereafter will be $25.

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement, you will be provided with information about your denial of your amendment and how you may appeal the denial of amendment. You have a right to a copy of the notice upon request.

COMPLAINTS

Calling this office or directing a letter to the office manager can handle complaints about your privacy rights or how your privacy is handled at this office. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights) 200 Independence Ave Room 509F HHH Building Washington, D.C. 20201

I have read this privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above

Patient's Name (Print) _____ Date: _____