Jordan CHIROPRACTIC & ACUPUNCTURE

2604 W. 9th St. Suite 100
Wichita, KS 67203

Tel: 316.269.2692
Fax: 316.269.4443

Today's Date _____

Patient Intake Form

PATIENT INFORMATION

DATE _____

Name (Last, first MI) _____Preferred Name_____

DOB _____ SS# _____

Address _____City _____ State ____ Zip Code _____

Email _____ Martial status_____ Gender M / F

Home # _____Cell # _____ Work # _____

*Referred By (Existing Patient, Internet, Phonebook, Walk in)
_____

EMPLOYMENT INFORMATION

Employer _____

Address _____ Phone # _____

EMERGENCY CONTACTS

Full Name _____ Relationship Spouse / Parent / Child / Other

Home # _____Cell # _____ Work # _____

Full Name _____ Relationship Spouse / Parent / Child / Other

Home # _____Cell # _____ Work # _____

BY LISTING INDIVIDUAL(S) NAMED ABOVE AS EMERGENCY CONTACT(S), YOU ARE AUTHORIZING JORDAN CHIROPRACTIC CLINIC TO RELEASE INFORMATION REGARDING THE NATURE OF YOUR EMERGENCY, AND YOUR LOCATION.

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VEHICLE ACCIDENT INFORMATION

Date: _____

Patient Name _____

Date of Accident _____ Time of Accident _____

Please Describe Accident in your own words: _____

_____

_____

_____

_____

Were you the __ Driver __ Front Passenger?
__ Rear Passenger __ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name: _____

City/State: _____

Driving Conditions __dry __ Wet __Icy __ other
Which direction were you headed _____
Speed you were traveling _____ MPH

VEHICLE

Make and model of the vehicle you were in
_____

Were you wearing a seatbelt? __Yes __ No
If yes, what type __ Lap __ Shoulder?
was the vehicle equipped with airbags?
__ Yes __No
If yes, did they inflate properly?
__ Yes __No
Did your seat have a headrest? __ Yes __No
If yes, what was the position of the headrest?
__ Low __ mid __ High

Is your headrest more or less than 1" from?
From the back of your head? _____

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IMPACT

Did your car impact another vehicle? __Yes __No
Did your car impact a structure: __ Yes __ No
If yes, explain
_____
_____

Did any part of your body strike anything in the vehicle? __ Yes __No
If yes, explain _____

Did your car impact a structure? __Yes __ No
If yes, explain _____

Was the impact from __ Front __ Rear __ Left __ Right __ other _____

At the time of impact were you __ looking straight ahead __Looking to the left __Looking up
__ looking to the right __Looking down

Were both hands on the steering wheel? __ Yes __ NO
If no, which hand was on the wheel? __ Right __ Left
Was your foot on the break? __ Yes __ No
If yes, which foot was on the break? __ Right __ Left
Were you __ Surprised by impact __ Braced for impact?

OTHER VEHICLE

Make and model of other vehicle
_____

Which direction was the other vehicle headed?
_____

Was the vehicle that struck you larger or smaller than your vehicle?

Estimated speed of vehicle?
_____

POLICE

Did the police come to the accident? __ Yes __ No
Were there any witnesses? __ Yes __ No
Was a police report filed? __ Yes __ No
Was a traffic violation issued? __ Yes __ No
If yes, to whom?
_____

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PATIENT CONDITION

Were you unconscious immediately after the accident? __ Yes __ No

If yes, for how long? _____ please describe how you felt immediately after the accident
_____
_____
_____

TREATMENT

Did you go to the hospital? __ Yes __ No
When did you go? __ Immediately __ Next Day __ 2 days or more after the accident
How did you get to the hospital? __ Ambulance __ Private transportation
Name of hospital/Dr_____

Treatment received _____
_____

X-rays taken __ Yes __ No
CT Scan Taken __ Yes __ No
MRI Scan Taken __ Yes __ No

SYMPTOMS/INJURIES

Have you been able to work since this injury? __ Yes __ No
How many days have you missed? _____
Prior to the injury were you able to work on an equal basis with others your age? __ Yes __ No

If you had any of the following symptoms since your injury, please check:

__ Headaches	__ Shortness of Breath	
__ Sleep Difficulty	__ Upset Stomach	__ Ear buzzing
__ Ear Ringing	__ Memory Loss	__ Blurred Vision
__ Fatigue	__ Nausea	__Numbness: Where_____

__Other_____

Is this condition getting progressively worse? __ Yes __ No __ Unknown

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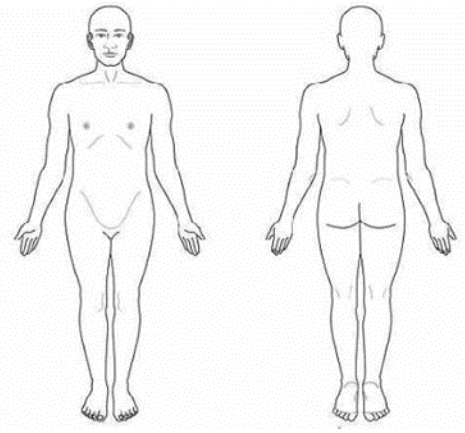
Mark the areas(s) of discomfort w/corresponding letter(s) on the diagram below.

S: Sharp A: Achy B: Burning N: Numbness T: Tingling O: Other



Rate the severity of your pain on a scale form 1-10 _____
Is it constant or does it come and go? _____
Does it interfere with your __ work __ sleep __ daily routine __ recreation?
Activities or movements that are painful to perform __ sitting __ standing __ walking __ bending __ laying down

Past Health History

Surgeries – Date, Type, and Reason NONE _____

Lifestyle (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins) _____

Major Injuries/Traumas: NONE _____

Major Hospitalizations: NONE _____

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs (List) _____

I certify that the above information is correct to the best of my knowledge.

_____ _____
Patient Signature Date

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Financial Policy

Dear Patient:
Thank you for choosing us as your health care provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered.
    - We accept cash, checks, Visa, MasterCard, Discover, and American Express.
    - We reserve the right to collect before services are rendered.
- All charges are your responsibility whether the insurance company pays or not.
    - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
    - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
    - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
- Unless you are insured by Medicare or an insurance group which our doctors are participating members, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered.
- If you are a member of an HMO or Managed Care Program or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company.
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account. You may reach an Account Manager at (316) 269-2692. Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Signature _____ Date _____

Patient's or Guarantor's Signature _____ Date _____

Witness Signature _____ Date _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form, discuss it with your chiropractor if you would like to, and then sign where indicated at the bottom.

Chiropractors who use spinal manipulative therapy techniques, such as for example joint adjustment, manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment. In particular:

A) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manipulative therapy.

B) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation, or mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.

C) There have been reported cases of disc injuries following spinal manipulative therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches, and other similar symptoms. Treatment provided at this clinic may also contribute your overall well-being. The risk of injury or complication from manipulative treatment is substantially lower than the risk associated with many medications or other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Your chiropractor will evaluate your individual case, provide an explanation of care, and suggest a treatment plan, or if necessary, a referral for consultation and/or further evaluation by a different physician if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my chiropractor the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my chiropractor including joint adjustment, manipulation, or mobilization to the joints of my spine (neck and back), pelvis, and extremities (shoulder, and upper limbs, and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Date_____

_____
Patient Signature

Name: _____
(Print Name of Patient)

Name: _____
(Name of Witness)

_____
Signature of Guardian

Name: _____
(Print Name of Guardian)

Name: _____
(Name of Witness)

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Many of the safeguards have been our policy and practice for many years. *Please read the following information and provide your consent.*

I hereby give my consent for Jordan Chiropractic and Acupuncture Clinic to use and disclose **protected health information (PHI)** about me to carry out treatment, payment, and administrative matter as required for my care.

I understand and agree that this specifically includes the sharing of information including PHI with other healthcare providers, laboratories, insurance payers, and vendors as is necessary and appropriate for my care.

I also agree to the normal procedures utilized by Jordan Chiropractic and Acupuncture Clinic for the handling of patient information and records, PHI, and other documents.

It is the policy of Jordan Chiropractic and Acupuncture Clinic to remind patients of appointments via telephone, email, postcards, letters, or by any other means that are convenient for Jordan Chiropractic and Acupuncture Clinic and or as requested. With this consent, Jordan Chiropractic and Acupuncture Clinic may call my home or alternative location and leave a message on the voice mail or in person in reference to any items that assist the practice in carrying out treatment operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory test results, among other items.

By signing this form, I am consenting to allow Jordan Chiropractic and Acupuncture Clinic to use and disclose my PHI to carry out practice operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Jordan Chiropractic and Acupuncture Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jordan Chiropractic and Acupuncture Privacy Officer, 2604 W. 9th suite #100 Wichita, KS 67203.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jordan Chiropractic and Acupuncture clinic may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

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Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient's Legal Name: _____

Birth Date: _____

I HEREBY AUTHORIZE JORDAN CHIROPRACTIC & ACUPUNCTURE CLINIC TO SHARE:

- Any health information including personal records and/or medications
- Account information such as balance, or appointment time, date, or reason for visit
- The following information (specify):

_____

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

I understand that I may cancel this consent at any time with written notice to Jordan Chiropractic Clinic, canceling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my Chiropractic provider to share my information with someone.

This authorization expires: □ When I cancel it in writing □_____

If no expiration date or event is specified, this authorization will expire (1) year after the date it is signed.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian)*_____

If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court power of attorney)

Witness: _____ Date: _____