

SUGAR HILL FAMILY CHIROPRACTIC

WELCOME

Welcome to a better way to achieving true health. Thank you for choosing our office for chiropractic health care. We are committed to providing you and your family with the highest quality of corrective and wellness care available so that you can enjoy an active, healthy life. We will be working together to help you and your family to reach all of your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions should be answered during your chiropractic report and new patient orientation.

The following forms should be filled out as thoroughly as possible in order for the doctors to find the cause of your problems. Please answer all questions, even if you feel it doesn't apply to chiropractic or your chief complaint.

We look forward to a long, healthy relationship.

Yours in health,

Dr. Debra A. Cirone

Dr. Joseph S. Clarino

and staff

SUGAR HILL FAMILY CHIROPRACTIC

Is this visit for: Wellness A specific Condition Today's Date _____

First Name _____ M.I. _____ Last Name _____

Phone _____ Cell _____ Work _____

Email address: _____

Address: _____ City: _____ St: _____ Zip: _____

DOB _____ Age _____ SS# _____ Married/Divorced/Widowed/Single

Occupation _____ Employer _____

Address _____ City _____ St _____ Zip _____

Whom may we thank for referring you to us? _____

Emergency Contact: _____ Phone: _____

Who is responsible for your account? _____

Do you expect your insurance to participate in the payment of your care? Y / N

Primary Insured? _____ DOB _____ SS# _____

Chief Complaint

What is your reason for seeking care: _____

When did it begin? _____ What was the cause? _____

Describe the pain: (check all that apply)

Sharp Throbbing Numb Continuous Interferes with daily activities

Dull Tingling Spasm Comes and Goes Frequency

Achy Burning Weak Radiates ... Where? _____

Rate Intensity of the pain: (Circle only one) **0 = no pain** **10 = unbearable pain**

0 1 2 3 4 5 6 7 8 9 10

Have you ever had the same or a similar problem before? Y / N If yes please explain:

Have you ever had treatment for this condition before? Y / N If yes please explain:

Have you ever had *any type of* surgery? Surgery and Date: _____

_____ Was it a success? Y / N _____

Are you currently taking medications? (including OTC's) List: _____

_____ What are the Side Effects? _____

List other health concerns: _____

Yes No (Before answering the following think all the way back to your childhood...and please explain)

- Physical Trauma?** (slips/falls...) _____
- Major or Minor Accidents? _____
- Played Sports? _____
- Sports Injuries? _____
- Job Related Injuries? _____
- Repetitive motions on the job? long sitting long standing lifting driving
- Broken Bones, sprains/strains, scars? _____
- Emotional Stress?** _____
- Work or Family Stress? _____
- Chemical Stress?** _____
- Did/Do you smoke or use tobacco? _____
- Did/Do you drink alcohol? How much? _____ How often? _____
- Do you eat processed foods or sugar free or **diet** products? _____

---Your History---

-----Your Family's History-----

-----Your Details-----

Symptoms	Present	Past	Father	Mother	Spouse	Child	Explain
Allergies							
Arm/Elbow/Hand Pain							
Arthritis							
Asthma							
Back Pain							
Cancer							
Diabetes							
Digestive Problems							
Dizziness/Nausea							
Fatigue							
Headaches							
High Blood Pressure							
Heart Trouble							
Jaw Pain							
Menstrual Probs.							
Neck/ShoulderPain							
Scoliosis							
Sinus Trouble							
Stroke							

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X-RAY & TREATMENT CONSENT

I, _____, give my consent to the doctors and staff of Sugar Hill Family Chiropractic to perform any examinations, treatments, and x-rays that are deemed necessary.

I agree to be responsible for the full amount of the services rendered.

Signed _____ Date _____

If this visit is for a child under 18 years of age please verify the child's name:

What is your relationship with this child? _____

Are you the legal guardian? Y N

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will by which it will be attained. This will prevent any confusion or disappointment.

Health: A state of physical, mental and social well being, not merely the absence of symptoms, disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 moveable vertebra in the spinal column puts abnormal pressure on the delicate nervous system causing interference thus distorting the vital communication between the brain and the body. This interference diminishes the body's inborn, innate ability to express it's maximum health potential.

Adjustment: The specific application of forces applied by the chiropractor to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area.

Regardless of what your symptoms, condition or disease may be, 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 the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signed _____

Date _____

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OFFICE FEE SCHEDULE & FINANCIAL POLICY

<u>Service</u>	<u>Fee</u>
Consultation	\$55-\$150
Initial Exam	\$70-\$150
Re-exam	\$70
X-Rays	\$40-150
Adjustment	\$55 and above

Chiropractic Health Care Plans for the individual or family to make care much more affordable.

Financial Policy and Chiropractic Health Care Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless arrangements to participate in and Active Life Plan are made in advance. **Chiropractic Health Care Plans** include yearly Corrective Adjustment Plans (CAP), monthly CAP plans or extended payment plans. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed during your Financial Consultation.

◆**Health Insurance:** Although we accept insurance in this office, not all insurance companies choose to cover chiropractic. Unfortunately their first line of business is making money. If you find that it does cover the services offered in our office, we will be happy to send claims directly to your insurance company. If we find out that you're responsible for your health care expenses don't be alarmed. **Most of our patients are on one of the Chiropractic Health Care Plans** discussed above. Regardless of your situation, this is the best way to keep costs down and get you all the care you need.

If you acquire insurance for a special situation such as an auto accident or a workers compensation injury and choose to utilize that coverage, your new insurance company will be charged our regular office fees until such claim is settled. We will also do our best to answer an questions of legal concern regarding your new case. Once the claim is complete, we will reinstate your Active Life Plan.

I have read and I understand the above policies.

Signed _____ Dated _____

Sugar Hill Family Chiropractic
Authorization Form

Name _____
SS# _____ Date of Birth _____

*THE PERSON IDENTIFIED ABOVE AUTHORIZES **DRS. CIRONE AND CLARINO AND SUGAR HILL FAMILY CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING.*

SPECIFIC AUTHORIZATIONS

1. I give permission to Drs. Cirone and Clarino and Green and Sugar Hill Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed reservations, birthday cards, holiday related cards and information about treatment alternatives or other health related information.
2. If **Sugar Hill Family Chiropractic** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
3. I give **Sugar Hill Family Chiropractic** permission to treat me in a semi-open room where other patients are also being treated. I am aware other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for these conversations.
4. By signing this form you are giving **Sugar Hill Family Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date **01/01/2015**

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Sugar Hill Family Chiropractic. The written notice must contain the following information:

You're NAME, SS NUMBER and your DATE OF BIRTH
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request, and your signature
The revocation is not effective until Sugar Hill Family
Chiropractic receives it.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Sugar Hill Family Chiropractic will not refuse to provide care.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Print Name of Patient _____

Signature of Patient _____ Date _____

Signature of Privacy Official _____

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