Thomas Chiropractic/Wagnon Chiropractic – Confidential Patient Information

Name_____ M__F__ Date _____

Address _____City_____Zip_____

Preferred Phone #_____ E-Mail_____

Birth Date _____ Age _____ Married Yes No

Occupation _____Spouse's Name _____

Emergency Contact _____Phone_____

Whom can we thank for referring you? _____

Health Concerns:

- o Neck
- o Mid Back
- o Low Back
- o Hips
- o Knees
- o Ankles
- o Feet
- o Headaches
- o Jaw
- o Sinuses
- o Posture
- o Cancer
- o Shoulders
- o Elbows
- o Wrists
- o Carpal Tunnel
- o Hands
- o Anxiety
- o Depression
- o Indigestion
- o Heart Burn
- o Sleep
- o Whiplash
- o Osteoporosis
- o Constipation
- o Diarrhea
- o Heart
- o Lungs/Asthma
- o Liver
- o Kidneys
- o Bladder
- o Prostate
- o Uterus/Ovaries
- o Weight
- o Diabetes
- o Auto Accident

Additional information or remarks _____.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Thomas and/or Wagnon Chiropractic will prepare reports and forms necessary to assist me in collecting from the insurance company. However, I clearly understand that any services rendered me are charged directly to me and that I am personally responsible for payment at or before the time of service unless otherwise agreed upon by Thomas and/or Wagnon Chiropractic and me. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

PRIVACY CONFIDENTIALITY STATEMENT

This notice describes how 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 the event of an emergency. Be assured that we will not disclose any information without your express written consent unless compelled to do so by legal authority.

Missed Appointment
It is our policy to call your home or office when an appointment is missed. If you are not home, we will leave a message on your answering service or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us of the number you would prefer us to use.

Mailings
It is our policy to send a birthday postcard on or near the date of a patient's birthday. We also send reminder cards and thank you cards to patients. If you would prefer that we discontinue mailings to your home, please inform a member of the staff and your name will be removed from future mailings.

Facility Set-Up
While our examination rooms are private, this office uses an open adjustment setting. The staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source of the information, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or healthcare operation, or the law otherwise restricts the accounting.
- You have the right to impact and have a copy of your health information. There will be a fee for this service.
- 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 our denial of your amendment and how you may appeal the denial of the amendment.
- You have the right to a copy of this notice upon request.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to Dr. Thomas by calling this office or directing a letter to his attention. 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 Avenue SW, Room 509F HHH Building, Washington, DC 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 Name:_____

Patient Signature:_____ Date: _____ /_____ /_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including various modes of physical therapy, diagnostic x-rays, examination tests, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand and I am informed that the results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all health care treatments, there are certain complications which may arise during a chiropractic adjustment, including, but not limited to: muscle strain, aggravating and/or temporary increase in symptoms, fractures, disc injuries, dislocations and sprains, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Jared Thomas, D.C. **Eric Wagnon, D.C.**

Thomas Chiropractic
720 Sunrise Ave. #104
Roseville, CA 95661
(916) 780-1370

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____
Printed Name of Patient Date

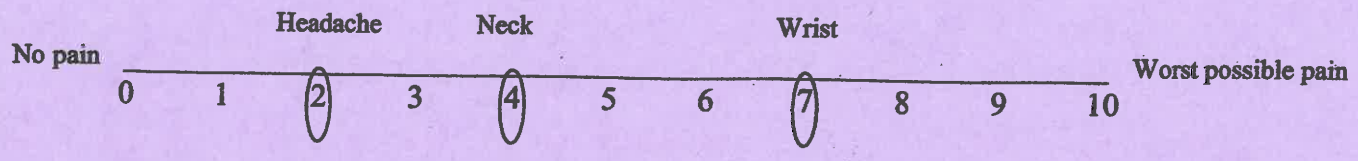
_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative Date

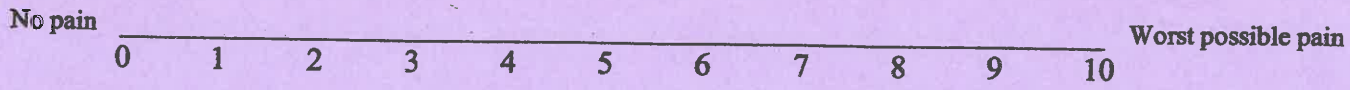
Visual Analogue Pain Scale

INSTRUCTIONS: Please circle the number that best describes the questions being asked. If there is more than one area of complaint you may indicate the area above and then circle the correct number that corresponds to your pain level for each question.

Example:



1. What is your pain right now?



0 = No Pain

1 = Very Mild Pain

2 = Minimal Pain

3 = Nominal Pain

4 = Mild Pain

5 = Moderate Pain

6 = Moderately Severe Pain

7 = Acute Pain

8 = Severe Pain

9 = Very Severe Pain

10 = Remarkebly Severe Pain

Name:_____ **Age:**_____ **Date**_____ **Score**_____

Patient Signature_____