DEAN'S CHIROPRACTIC CENTER

1225 S. Main St. Suite 201, Greensburg PA 15601 Phone: 724-836-7246 Email: DeansChiropractic@gmail.com

PATIENT INFORMATION

Welcome to Our Office

Patient Name_______________________________**Date of Birth**_______________**SS#**_______________________

Address_______________________________**City**_______________________**ST**________**Zip**___________

Home Phone________________________**Cell**________________________**Work Phone**___________________

☐ Male ☐ Female **Email Address**_______________________________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Name_______________________________________**Occupation**_______________________________

Spouse's Name_________________________ _________________________**Date of Birth**__________________

Spouse's Employer______________________________**Spouse's Occupation**_________________________

Emergency Contact Name_________________________**Phone**____________________**Relationship**____________

How were you referred to us?____

Primary Care Doctor:____

Previous Chiropractor__________________**Last visit:**__________**Why are you changing?**______________________

❑ NONE	MEDICATION NAME	DOSAGE	What are you taking it for?

❖ If more than 5 medications, list on back of form

❑ NONE	LIST SURGERIES OR ACCIDENTS/ INJURIES	WHEN

❑ NONE **ALLERGIES** **List ALL allergies**____

How many children: 0 1 2 3 4 _______________ **Family history of:** ❒ Heart ❒ Diabetes ❒ Thyroid ❒ Cancer

Smoking Status: (Circle one) Never Smoked Former Smoker Smoker ____ packs day **Alcohol:** None Social _ ______drinks/ week

Exercise: Excellent Good Poor **Diet:** Excellent Good Poor **Sleep:** Excellent Good Poor **Water Intake** Excellent Good Poor

Complaint ____

Started When_____________ _________________________________

Cause of Pain____

Pain is ○ Aching ○ Sharp ○ Deep ○ Numbness and Tingling ____________

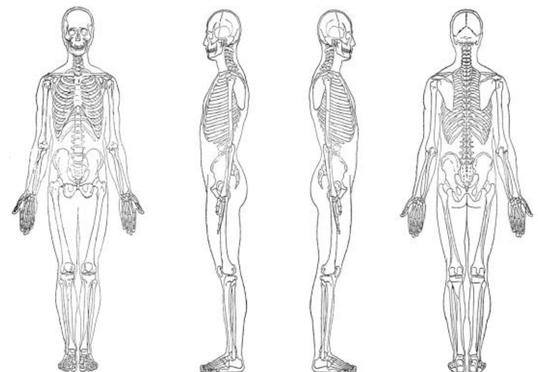
Does pain go down your arm or leg? ○ No ○ Yes______________ left or right

From 0-10 (0 no pain and 10 being the worst pain) Yours is ___________/10

Pain is ○ Constant (100-76%) ○ Frequent (75-51%) ○ Occasionally (50-26%) ○ Intermittently (25-0%)

What makes it worse?_______________________________________

What gives you relief?_______________________________________



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Name: ____ **Date**_______________________________

☑ **Check the boxes that apply to you.**

REVIEW OF SYSTEMS

❑ **None I have reviewed this entire page and NONE of the following conditions listed below apply to me.**

❑ None CONSTITUTIONAL	Past	Now	❑ None CARDIOVASCULAR	Past	Now	❑ None MEDICALCONDITIONS	Past	Now
Lack of Energy			Heart Disease			Alcoholism		
Unexplained weight gain			Shortness of Breath			AIDS/ HIV		
Unexplained weight loss			Heart Palpitations			Anemia		
Diagnosis of Cancer			Heart Murmur			Anxiety		
			Ankle Swelling			Asthma		
❑ None EENT	Past	Now	Chest Pain			Arthritis		
Frequent Sinus Infections			Pain in Legs with Walking			High Blood Pressure		
Frequent Colds						Low Blood Pressure		
Deafness			❑ None RESPIRATORY	Past	Now	High Cholesterol		
Earaches			Chronic Cough			Cancer		
Chronic Sinus Infections			Difficulty Breathing			Diabetes Type 2		
Ringing in ears			Wheezing			Diabetes Type 1		
Swallowing Problems						Diverticulitis		
			❑ None ENDOCRINE	Past	Now	Depression		
❑ None GASTROINTESTINAL	Past	Now	Excessive Thirst			Eczema		
Gallbladder Problems			Low Blood Sugar (hypoglycemia)			Epilepsy		
Constipation			High Blood Sugar (hyperglycemia)			GERD		
Diarrhea			Shortness of Breath			Heartburn		
Indigestion			Adrenal Dysfunction			Hiatal Hernia		
Excessive hunger			Unexplained Hair Loss			Hemorrhoids		
Poor Appetite			Excessive Fatigue			Heart Attack		
						Heart Murmur		
❑ None PSYCHIATRIC	Past	Now	❑ None GENITO-URINARY / LIVER	Past	Now	Herpes		
Frequent Sadness			Frequent Bladder Infections			Hepatitis A B C		
Mood Swings			Kidney Stones			Irritable Bowel Syndrome		
Suicidal Thoughts			Painful Urination			Inguinal Hernia		
Phobias/ Unexplained Fears						Mitral Valve Prolapse		
			❑ None MUSCULOSKELETAL	Past	Now	Osteoporosis		
❑ None SKIN	Past	Now	Arthritis			Pneumonia		
Bruise Easily			Hernia			Rheumatoid Arthritis		
Very Dry Skin			TMJ (Jaw Pain)			Stroke		
Hives / Rash			Bursitis			Thyroid - Hypothyroid		
Itching			Joint Swelling			Thyroid - Hyperthyroid		
Varicose Veins						Ulcers		
Skin boils or lesions			❑ None FEMALES ONLY	Past	Now	Anything else not listed:		
			Hot Flashes					
❑ None NEUROLOGIC	Past	Now	Excessive Menstrual Flow			❑ None ALLERGIES	Past	Now
Frequent headaches			Headaches around Menses			Seasonal		
Tremors / Hands shaking			Breast Pain			Latex		
Stroke			Fibroids			Penicillin		
Seizures / Convulsions			Frequent Yeast Infections			Sulfa Drugs		
Double Vision			Excessive Fatigue			Bee Stings		

Patient Initials_________

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Patient Name **x**____

(Printed)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or declined your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my confidential information is used or disclosed to carry out treatment, payments and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list the name(s) who we may share your medical information with: ❑ **None**

Spouse/Partner________________________Parent________________________Child________________________

X____ ______________________

Patient / Guardian Signature **Date**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Chiropractor(s) who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the Chiropractor(s) at Dean's Chiropractic Center LLC.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' 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 all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

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 have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

X____ ______________________

Patient / Guardian Signature **Date**

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Patient Name **X**____
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ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dean's Chiropractic Center, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

X____ ______________________________
Patient / Guardian Signature **Date**

TEXT / EMAIL MESSAGE ACCOUNT ALERTS

I authorize DEAN'S CHIROPRACTIC CENTER, LLC to send text /email message appointment reminders to me on my provided cell phone number or email address. I understand that I may reply with various commands to receive account information such as appointment reminders, schedule next appointment, patient satisfaction surveys, health tips and communicating new services or products. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply. It is important to note that text or email communications are not always secure. Text messages and emails can be intercepted and for this reason, we do not communicate personal health information through this method.
My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text or email messaging services. I understand that this authorization can only be revoked in writing.

X____ ______________________________
Patient / Guardian Signature **Date**

MISSED APPOINTMENT / NO SHOWS

A "no show" is someone who misses an appointment without canceling it in an acceptable manner. When a patient does not show up for their appointment, we lose the opportunity to see and help someone else. A missed appointment will be recorded in the "patient's file. The first time there is a "no show", there will be no charge. Any additional "no show" will result in a fee of $40 being billed to the patient's account. "No show" fees are the patient's responsibility and must be paid before your next appointment. The fee cannot be billed to your insurance company.
Multiple "No Shows" in any 12 month period will result in termination from our practice. Thank you for you anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

X____ ______________________________
Patient / Guardian Signature **Date**

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Patient Name **x**____

(Printed)

GOOD FAITH ESTIMATE AND DISCLOSURE

You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for health care items and services before those services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any nonemergency health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing at least 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask your health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, www.cms.gov/nosurprises or email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Disclaimers: There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. The information provided in this Good Faith Estimate is only an estimate of items or services reasonably expected to be furnished at the time this Good Faith Estimate was and actual items, services, or charges may differ from the good faith estimate.

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400 more than the expected charges included in the Good Faith Estimate and the dispute is initiated within 120 days after the date of the bill for the items or services. To start the process, you may contact us at the phone number or address listed above to let us know the billed charges are higher than the Good Faith Estimate. You can ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services within 120 calendar days (about 4 months) of the date on the original bill and if the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. This Good Faith Estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

FEES

New Patient Exam $40-150	**Established Patient Exam $20-125**	**Nutrition Visit $45 per 15 min**
CMT $20-50	**Ultrasound $ 10-15**	**EMS $10-15**
Therapeutic Exercises $25	**Traction $15-50**	**Manual Therapy $25**
Wellness visit $20-40	**Supportive care visit $20-40**	**Laser Treatment $50-60**
Kinesiology Taping $15-20	**Weight Loss programs $200-1,200**	**Consultations $45 per 15 min**

x______________________________________ ______________________________

Patient / Guardian Signature **Date**