

WELCOME

Thank you for choosing Back In Motion Family Chiropractic for your chiropractic needs.

Confidential Patient Information

If you have any questions or concerns or if you are seeking care due to an auto accident or work related injury, please let us know.

(Please Print Clearly Using Ink)

Today's Date ____/____/____

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Mobile Phone # _____

Email Address _____

Birthdate ____/____/____ Sex F M

Your Employer _____ Occupation _____

Person to contact in case of emergency _____

Phone # _____

Who may we thank for referring you to us? _____

Family Information

Marital Status S M D W # of Children _____ Ages _____

Spouse/Partner's Name _____ Occupation _____

Financial Responsibility

Who is responsible for this account? _____

Relationship to patient _____

The fee for today's initial visit is \$100.00.

How will you be paying for today's visit? Cash Check Credit Card

If you would like this office to verify chiropractic benefits and/or bill your insurance company regarding this account, please be sure our office has a photocopy of your insurance card.

If you have chiropractic benefits the amount you pay today will be applied to your deductible and/or co-insurance.

Printed Patient Name _____ Date _____

Current Health History

What is your chief complaint? _____
 When did you first notice this? _____ How long ago? _____
 Have you had this problem before? _____
 What makes this condition better? _____
 What makes this condition worse? _____
 How often are symptoms present? (Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)
 How do you feel today? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
 In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, or household chores)
 (No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)

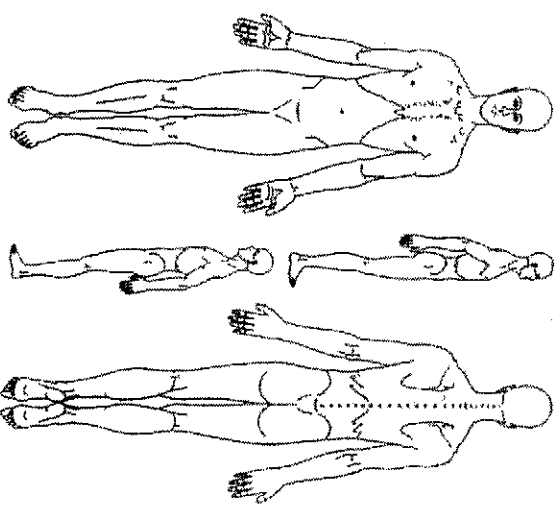
yes <input type="checkbox"/> no <input type="checkbox"/> Does the pain get worse at night? <input type="checkbox"/> <input type="checkbox"/> Is the pain unrelieved by position or rest? <input type="checkbox"/> <input type="checkbox"/> Does the pain interfere with your sleep?	yes <input type="checkbox"/> no <input type="checkbox"/> Does the pain radiate? If yes, where? _____ <input type="checkbox"/> <input type="checkbox"/> Have you received other treatment for this condition? If yes, what? _____ when? _____ by whom? _____ results _____
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Please list your symptoms or concerns below and the relative pain intensity (0 – 10) for each symptom. (Example: Low back pain – 4)

	No Pain	Mild	Moderate	Severe	Unbearable						
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

Please mark on the diagram to the right the type of pain you are experiencing using its abbreviation:

a=aching b=burning c=cramping d=dull n=numbness
 sh=sharp sho=shooting ss=spasming st=stiffness sw=swelling
 th=throbbing ti=tingling o=other



Informed Consent & Terms of Acceptance

The nature of the chiropractic adjustment: This office will use manual (hands on), a specialized table (drop) or an instrument (Activator) to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent to an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic adjustment. This may include, but is not inclusive to: sprains, fractures, disc injuries and stroke.

The probability of those risks: Fractures are rare and can result from underlying weakness in the bones. The other complications are also considered rare. A source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so, we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Other treatment options, outside this office, for your condition include, but is not limited to: Medical care with prescription drugs, self-management with over-the-counter medication, rest and/or surgery. There are material risks inherent in each of these options including, but not limited to: addiction to medication, side effects of medication, improper self-dosages and surgical risks including complications from the procedure and/or the anesthesia.

If during the course of our examination, we encounter findings that we feel need a referral we will recommend that you seek the services of a health care provider who specializes in that area.

PLEASE DO NOT SIGN BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction.

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 treatment recommended. Having been informed of the risks, I hereby give my consent to treatment and accept such treatment on these terms.

Printed Patient Name _____ Date ____/____/____

Patient Signature _____ Dr.'s initials _____

The patient had the following questions and was supplied the following answers:

GENERAL OFFICE POLICIES

- Please arrive for your appointment on or before the scheduled appointment time. If you are unable to keep your appointment, or will be late, please call our office to reschedule 24 hours prior to your scheduled appointment. A No-Show charge may be assessed if a call is not received within 24 hours for cancellations.
- Please bring your insurance card(s) to your appointment. If you change insurance companies or benefits, you must call us with the new information BEFORE your appointment. If you do not, you may be responsible for the charges.
- **Payment is expected at the time of service.** If you have an insurance co-payment, it will be collected before you see the provider. We accept cash, check, debit and all major credit cards.
- You must provide changes to your current personal information at each visit, especially changes in address, telephone, or daytime contact phone number as well as current insurance company information.
- We accept Medicare, and will bill Medicare and/or your secondary insurance for you. However, you may be responsible for any unpaid balance that Medicare does not cover (see Medicare ABN form).
- Should you receive any correspondence from your insurance company in regards to the services provided in our office, you must respond to that correspondence immediately in order to have the claim processed and paid. The primary insurance contract is between you (and/or your spouse) and the insurance company, or between you and the employer group-coverage carrier. Back In Motion bills as a courtesy to our patients, however the patient is ultimately responsible for making sure that we have correct information.
- If you have no insurance coverage or benefits for services rendered at Back In Motion, our charge for your care or the care of your dependents will be due and collected at the time of service.

I have read and understand the above information, and I agree to these terms.

Patient Printed Name: _____ Date: ____/____/____

Patient Signature: _____ Authorized by: _____



Dr. Debbie Casper
Dr. Heidi Voigt

CANCELLATION/NO SHOW POLICY

In order to ensure that quality patient care is maintained and all patients can be accommodated it is important that you notify Back In Motion Family Chiropractic of your intentions to cancel or change your appointment with our office at least **twenty-four business hours (24)** prior to your scheduled appointment by calling (480) 899-2440.

If no call is received within this time period you will be considered a "No Show". If the appointment is for acupuncture or muscle work, a fee of \$40.00 will be assessed.

Please take the time and consideration needed to provide the proper notification of your intent to cancel your visit with your Provider.

We understand there may be times you will miss an appointment due to an emergency or other obligation and we will take these situations into account, however, we strongly encourage you to inform us within 1 business day prior to your scheduled appointment so that we can help and accommodate another patient in that appointment slot.

I understand that with **three (3)** or more "No Show" appointments, Back In Motion Family Chiropractic has the right to discharge me from the practice. If discharged, Back In Motion Family Chiropractic will notify me in writing.

I, _____, have read and had the above policy explained to me. I agree to abide by the request to notify the practice at least one business day in advance of a scheduled appointment of my intention to cancel or change my appointment. I understand this assessment will not be charged to my insurance carrier and I will be responsible for any fees.

I have read the above information, and I agree to these terms.

Patient Printed Name: _____ Date: ____/____/____

Patient Signature: _____ Authorized by: _____

**Back in Motion Family Chiropractic
Privacy Practices and Medical Records Acknowledgement**

ACKNOWLEDGEMENT

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices and Medical Records Protocol.

Signature of Patient

Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of Personal Representative

Description of Authority

Date