ROBISON CHIROPRACTIC CLINIC

146 S. Elk - Casper, WY 82601

(307) 237-2050

Legal name:_____ **Date:**_____
First MI Last

Name you prefer to be called:_____ **SS#:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Hm Phone:_____ **Cell:**_____ **Work:**_____

Age:_____ **Birthdate:**_____ **Sex: M / F Marital Status: S / M / D / W**

Employer:_____

Emergency Contact Name:_____

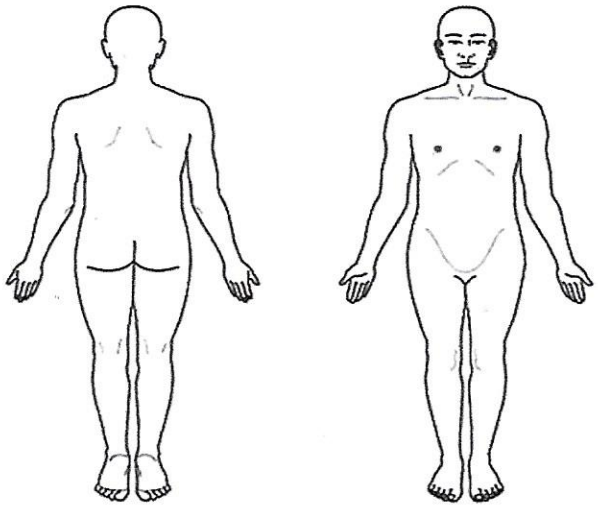
relationship:_____ **Phone:**_____

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.**
- **Our office policy requires payment in full for all services rendered at the time of visit. We accept cash, check, debit, and credit cards.**
- **If you have insurance, an insurance receipt is available for you. You submit the bill to your own insurance company. Any reimbursement from them will go back directly to you. Please inform us if you need one of these receipts.**
- **There will be a charge, equal to the adjustment price, for missing more than two appointments without letting our office know at least 2 hours in advance.**
- **Any account more than 30 days past due will be assessed interest at the rate of 3% per month until paid in full. If treatment is terminated by the patient, the account is immediately due and payable in full. In the event that we have to use a collection agency, you agree to pay all collection costs, attorney fees, and court costs.**
- **Thank you for selection our office! Together we can make a great chiropractic health team!**

Patient Signature:_____ **Date:**_____

CASE HISTORY

Please mark on the picture where your symptoms are, using the symbols below:



Numbness	X
Burning	/
Stabbing	#
Dull/Ache	o
Other	--

When did this condition begin?_____

How did it happen?_____

Is this an auto or work related accident?_____

Is it (please circle): **constant** **comes & goes** Is it getting: **better** **worse** **same**

Does it interfere with any activity? (explain)_____

Have you been treated before for this condition? _____

If yes, by whom, and what was the treatment? _____

List any medications: _____

List any broken bones: _____

List any surgeries: _____

List any diseases/conditions you have: _____

List any other information you would like the doctor to know:_____

_____

_____

_____

INFORMED CONSENT

To the patient: Please read this document prior to signing it. It is important that you understand the information contained in the document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. We use the hands or a mechanical instrument on your body in such a way to move your joints. That movement may cause an audible "pop", such like when you "crack" your knuckles. You may feel a sense of movement.

Risks: As with any healthcare procedure, the chiropractic adjustment carries with it some risks. The following are known risks:

- Soreness - It is not uncommon for patients to experience temporary soreness after the first few adjustments as the vertebra and muscles get used to their new position.
- Fractures - When patients have underlying conditions that weaken bones, like osteoporosis or cancer, they may be susceptible to fracture. It is important to notify the doctor if you have been diagnosed with a bone weakening disease or condition. The doctor can then modify your treatment plan to minimize the risk.
- Disc Herniation - Disc bulges and herniations may worsen, even with chiropractic care. While this is rare, it is important to notify the doctor if symptoms change or worsen.
- Stroke - A certain rare type of stroke has been associated with the chiropractic adjustment. These strokes, which may result in paralysis or death, are extremely rare. Estimates of the risk of these occurring are 1:500,000 to 1:5.8 million.

Alternatives to chiropractic care: Reasonable alternatives to chiropractic care include the following:

- Medications may be used to temporarily reduce pain and/or inflammation
- Rest/.Exercise - Rest may temporarily reduce pain/inflammation. The same is true for ice, heat, and other home therapies. Exercises are of value, but do not correct injured nerves or joint tissues.
- Surgery - May be needed for joint stability or serious disc rupture
- No Treatment - Neglected care may lead to increased pain, restricted movement, increased inflammation, and worsening symptoms. These may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I have read ( ) or have had read to me ( ) the above consent. Any questions I have had regarding these procedures have been answered to my satisfaction ***prior to my signing this consent form.*** I have made my decision voluntarily and freely.

Signature of patient:_____ **Date:**_____

Based on my personal observation and the patient's history, I conclude that the patient was:

( ) of legal age ( ) consent given through guardian ( ) alert and oriented ( ) on prescription or OTC medications but unimpaired

ROBISON CHIROPRACTIC CLINIC

HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Robison Chiropractic Clinic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The clinic has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The clinic reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the clinic does not have to agree to the restrictions
- The patient may revoke the consent in writing at any time and all future disclosures will then cease
- The clinic may condition receipt of treatment upon the execution of the consent
- The patient acknowledges that he/she has received a copy of our HIPPA practices

The consent was signed by:_____

Witness:_____