**Welcome to Ascend Chiropractic!**
**Kindly take a moment to familiarize yourself with our office policies and procedures.**

**Payment Policies and Procedures:**

Payment must be made in full at the time services are rendered.

HEALTH INSURANCE: We are an **out of network** provider. However, Health Savings Account (HSA) cards may be used for payment of treatment and proper receipts or documentation will be provided if needed by your HSA provider.

PERSONAL INJURY: At this time, Ascend Chiropractic does not take Personal Injury cases; however, we are happy to refer you to another provider who will handle your case.

**Appointments and Scheduling:**

We make an extra effort to stay on time and ask that you be on time as well.

A new patient visit is approximately 30-45 minutes in length and costs **$120.00**. A routine office visit is 15-20 minutes in length and costs **$65.00.**

If you have a new injury while under care, please let us know so we can provide necessary paperwork and schedule accordingly.

**Cancellation and Missed Appointment Policy:**

If you need to cancel your appointment, please do so **24 hours** prior to the time of the appointment to avoid charge. If you cancel without 24 hours' notice, **at the time of the 4th offense,** you will be responsible for the appointment fee. IF you miss your appointment, **at the time of the 4th offense,** you will be responsible for the appointment fee.

**FINANCIAL RESPONSIBILITY**: **** ASCEND CHIROPRACTIC WOULD LIKE TO INFORM YOU THAT WE DO NOT ACCEPT INSURANCE AS PAYMENT FOR SERVICES RENDERED; PAYMENT MUST BE MADE USING CASH OR CREDIT CARD AT TIME OF SERVICE****

**We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.**

I have read and understood the patient treatment consent policies of Ascend Chiropractic.

_____ _____

Signature Date

_____

Printed Name

# Ascend Chiropractic
**Patient Consent Form**

**Authorization for Care:**
I understand that chiropractic treatment consists of moving joints and soft tissues as well as physiotherapy modalities and exercise protocols. Although chiropractic care is considered a safe and effective tool for decreasing pain and improving activities of daily life, I am aware that the benefits are not guaranteed and the following are possible risks:

- Soreness: It is common for people to experience soreness after the first few treatments as the body responds to the new movement and posture.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are rare.
- Fracture: Patients with weak bones from underlying pathologies may be susceptible to injury.
- Stroke: This is a rare risk and there has been found to be no more risk of stroke occurring after seeing a chiropractor than after seeing a medical doctor.

I understand alternative treatments are available including non-treatment, rest, medication, and surgery, however, these also have associated risks. I have read, or have had read to me, the above consent and have had the opportunity to ask any questions regarding its content.

I,_____, hereby give my consent for chiropractic examination and treatment and authorize procedures as deemed necessary in the diagnosis and/or treatment of my condition.

Signature: _____ Date: _____

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**Protected Health Information:**
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that personal health care information be kept confidential. We understand the importance of your privacy and will do our best to maintain it.

- Only when it is appropriate or necessary, will we provide information regarding treatment, payment, or health care operations to a third party.
- We support your right to inspect and copy your personal medical records upon written request.
- You have the right to refuse consent or request restrictions on certain uses and disclosures of your health information. If you chose to give your consent, you have the right to revoke it, in writing, at any time.
- You have the right to review our Notice of Privacy Practices and speak with our staff, regarding questions.

I, _____, understand my right according to HIPAA and how my personal health care information may be used and disclosed.

Signature: _____ Date: _____

**New Patient Information**

Legal Name: (last) _____(first)_____(middle)
Email: _____Primary Phone: _____.
Address: _____City: _____.
State:_____Zip:_____ **Date of Birth:_____**
Married Single Partnered
Children: Yes / No How Many: _____.
Occupation: _____Patient Employer/School:
In Case of emergency, contact:_____Relationship:
Phone: _____.
Whom may we thank for referring you? _____.
Values: Please list 3 of your interests you value most below (ex: family, finances, faith, work, etc)

1. _____2. _____3. _____.

**Medications**

1.
2.
3.

None

**Vitamins/ Supplements**

1.
2.
3.
4.

How often do you take these?

**Allergies**

1.
2.
3.

How often do they occur?

**Family History**

*Please indicate if any blood-related relatives have/had the following:
Autoimmune Disease _____.
Bleeding Disorder_____.
Clotting Disorder_____.
Cancer_____.
Diabetes_____.
Heart Disease_____.
High Blood Pressure _____.
Kidney Disease _____
_____.
Migraines _____.
Osteoporosis _____.
Stroke _____.
Thyroid Disease _____.
Other_____

## Physical and Trauma Information

Injuries or Falls:_____.
Surgeries: _____.
Exercise: (none, light, moderate, heavy; How often: )
Habits: (nicotine, alcohol, coffee/caffeine, high stress level)
How much? _____How often? _____.
How many pregnancies:_____How many deliveries: _____
Birth Delivery: (vaginal, cesarean) Complications (if any): _____.

## Motor Vehicle Accident

Was this pain caused by a motor vehicle accident? _____.
Are you currently or will you be involved in litigation for this injury? _____
_____.
Have you had care for this injury already? _____.

## Medical History

Name and phone of other doctor(s):
_____.
_____.
**Date of Last:** Physical Exam _____Blood Test _____ Urine Test_____.
(female) PAP/breast exam _____(Male) Prostate exam_____.

**Circle the conditions below that YOU HAVE experienced and complete the information below:**

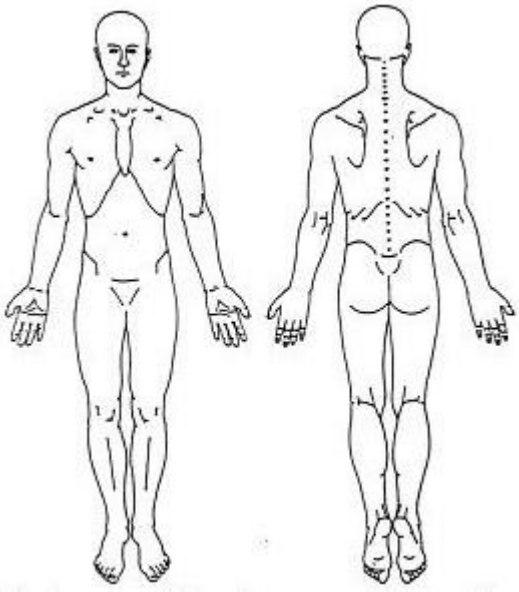
| | | |
|---|---|---|
| AIDS/HIV | Eating Disorder | Parkinson's |
| Alcoholism | Emphysema | Pinched Nerve |
| Allergies | Epilepsy/seizure disorder | Pneumonia |
| Anemia | Headaches | Prostate Problem |
| Anxiety/Depression | Heart Disease | Psychiatric care |
| Appendicitis | Hepatitis | Rheum. Arthritis |
| Arthritis | Hernia | STD |
| Asthma | Herniated Disc | Stroke |
| Autoimmune Disorder | Hypertension | Thyroid disease |
| Bleeding Disorder | Kidney Disease | Tuberculosis |
| Bronchitis | Liver Disease | Tumors, Growths |
| Cancer | Migraines | Ulcers |
| Chemical Dependence | Mononucleosis | **Other:** |
| Chicken Pox | Multiple Sclerosis | |
| Clotting Disorder | Osteoporosis | |
| Diabetes | Pacemaker | |

Are you pregnant? _____. If yes, how many weeks? _____. Other: _____.

ASCEND
CHIROPRACTIC

## Primary Complaint:

Primary complaint: _____.
When did your symptoms first begin? _____.
Most recent occurrence date: _____.
What do you think caused this problem? _____.
Is this condition getting progressively worse? _____
Mark an X where you feel your primary complaint:



Describe the pain (ex: sharp, dull, aching, tingling, burning): _____.
Does this pain travel from the primary point? _____.
How often does this pain occur? _____. Time of day pain occurs: _____.
Activities affected by this (ex: walking, standing, sitting): _____.
Past treatments: (medications, surgery, Physical therapy, chiropractic, other, none)
Pain worsens with: _____Pain improves with: _____.
**Is there anything else you would like the Doctor of Chiropractic to know?**