BODY RIGHT CHIROPRACTIC S.C.

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name_____Birthdate _____

Address_____City_____Zip_____

SSN_____ Marital Status S M W D Gender M or F

Phone_____Cell_____e-mail_____

Employer_____Occupation_____Work Phone_____

Would you like to receive text or e-mail reminders? Y or N Cell Provider_____

Spouse's Name_____Phone_____Employer_____

Have you been adjusted before? Yes or No Is pain work or auto accident related? (Circle)

Mark an "X" on the picture to show the areas you are having pain or discomfort

When did symptoms start?_____

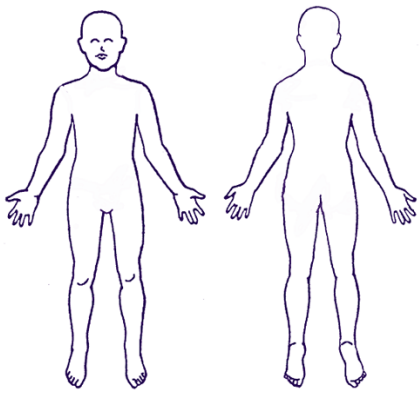
How did they occur?_____

Rate your pain on a scale of 0 to 10 _____

Do you have any current X-rays? Yes or No

Are you pregnant? Yes or No

Seeking treatment with any other provider for this issue? Yes or No



Type of pain (please circle): Sharp Dull Throbbing Numb Achy Shooting Other _____

Is your pain getting worse, better, or staying the same? (Circle) Is the pain constant? Y or N

What makes the pain better? _____What makes it worse? _____

Circle any of the following that are painful: Sitting Standing Walking Bending Sleeping Lifting

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List past surgeries and accidents/injuries:_____

_____

Current medications?_____

Allergies?_____

Please list any major illnesses or current condition (HBP, diabetes, asthma, heart, stroke, etc.)

_____

List skeletal injuries/conditions (broken bones, arthritis, degeneration): _____

_____

Family health history: Heart/Cancer/Diabetes/other:_____

Do you smoke (Y or N), drink caffeine (Y or N) or consume alcohol (Y or N)?

Work Habits (Circle): Mostly Lifting Mostly Standing Mostly Walking Mostly Sitting

Any additional information you feel is relevant to your care :

_____

_____

I CERTIFY THAT I AM THE PATIENT OR LEGAL GUARDIAN LISTED ABOVE. I HAVE READ/UNDERSTAND THE INCLUDED INFORMATION AND CERTIFY IT TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE COLLECTION AND USE OF THE ABOVE INFORMATION TO THIS OFFICE OF CHIROPRACTIC. I AUTHORIZE THIS OFFICE AND ITS STAFF TO EXAMINE AND TREAT MY CONDITION AS THE DOCTOR(S) SEE FIT. I, HEREBY, AUTHORIZE THE DOCTOR(S) TO RELEASE ALL INFORMATION NECESSARY TO ANY INSURANCE COMPANY, ATTORNEY OR ADJUSTER FOR THE PURPOSE OF CLAIM REIMBURSEMENT OF CHARGES INCURRED BY ME. I GRANT THE USE OF MY SIGNED STATEMENT OF AUTHORIZATION FOR REQUIRED INSURANCE SUBMISSIONS. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME WILL BE CHARGED TO ME, AND I AM RESPONSIBLE FOR TIMELY PAYMENT OF SUCH SERVICES. I UNDERSTAND AND AGREE THAT HEALTH/ ACCIDENT INSURANCE POLICIES ARE ARRANGEMENTS BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT THE FEES FOR PROFESSIONAL SERVICES WILL BECOME IMMEDIATELY DUE UPON SUSPENSION OR TERMINATION OF MY CARE OR TREATMENT.

PRINTED NAME_____

SIGNATURE_____DATE_____

BODY RIGHT CHIROPRACTIC S.C.

333 North 8th Street. Medford, WI 54451

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices and have completed the "Acknowledgement of Receipt of the Notice of Privacy Practices."

Authorization for Use & Disclosure of Protected Health Information (PHI) and Wisconsin Consent

I understand that by signing below I authorize the Use and Disclosure of my Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that Body Right Chiropractic "BRC" has reserved the right to make changes to the privacy practices as necessary. If BRC makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that Body Right Chiropractic maintains.

Check any additional Use and Disclosure authorizations that may apply:

☐ I consent to disclosure of my patient health care records for disaster relief purposes as permitted by law.

☐ I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care. [Specify person(s) below]:

_____ _____
(Person Name) (Relationship

_____
(Address)

_____ _____
(Person Name) (Relationship)

_____
(Address)

_____ _____
Signature Date

BODY RIGHT
CHIROPRACTIC
S.C.

INFORMED CONSENT: CHIROPRACTIC CARE & ADJUSTMENTS

I hereby request and consent to receiving Chiropractic Manipulations (Adjustments) and other Chiropractic procedures, including various Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for, BRC now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, 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, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time based upon the facts then known.

I also understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include, but are not limited to: rest; self-administered care; over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I acknowledge that the Doctor of Chiropractic has discussed with me the following items:

- Explanation of my current condition;
- Proposed Chiropractic procedures;
- Risks of not receiving or undergoing any treatments or procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below (for whom I am legally responsible), whether in my presence or absence.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Guardian/Legal Representative Name (Print)	Guardian/Legal Representative Signature	Date