Fletcher Heights Chiropractic

Dr. Nicholas Jay

Date:_____
Patient name:_____
Last name

_____
First name **Middle initial**

Address:_____
City:_____ **State:**_____ **Zip code:**_____
Email:_____
Sex: Male Female Age:_____
Date of birth:_____
Home phone:_____
Cell Phone:_____
Secondary phone:_____
Preferred contact method: Home Cell

Occupation:_____
Employer:_____
Employer phone number:_____

Married widowed single minor divorced separated partner

Emergency contact:_____
Relation:_____
Phone:_____

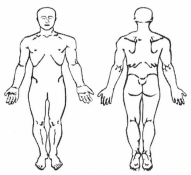
Spouse's name:_____
Phone Number_____
Date of birth:_____

Whom may we thank for referring you?
_____

Primary care physician:_____
Phone number:_____

Have you had an x-ray, CT, MRI in the last year?
Yes No
Where did you have the x-ray taken?
_____

Are you pregnant? Yes No
Due date:_____



Mark and X on the picture where you continue to have pain, numbness, or tingling.
Reason for your visit:_____
When did your symptoms appear?_____
Is this condition getting progressively worse? Yes No Unknown
Please rate the severity of your pain on the scale below:
Mild: 0 1 2 3 4 Moderate: 4 5 6 Severe: 7 8 9 Extreme: 10

Type of pain: __Sharp __Dull __Throbbing __Numbness __Aching __Shooting __Burning __Tingling __Cramps __Stiffness __Swelling __Other

How often do you have this pain?_____
Does it interfere with you: ***work sleep daily routine recreation***
Activities or movements that are painful to preform: ***sitting standing walking bending lying down***
What treatment have you already received for your condition? ***Medication surgery physical therapy***
Chiropractic services none other_____
Name and phone number of other doctor(s) who have treated you for your condition:
_____

Is this condition due to an accident? Yes No Date of accident**:**_____ Type of accident**: Auto Work Home Other**
Current medications, including dosage if known. If there are no medications chereheck:
1._____ **2.**_____ **3.**_____
4._____ **5.**_____ **6.**_____

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•In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. As a reminder: Your **insuran**ce policy is a contract between you and your insurance company, the doctor is not involved. You are responsible for knowing your insurance benefits. *Unless other arrangements have been made in advance by either yourself or your health **coverage carrier, full payment is due at the time of service.** For your convenience we accept VISA, MasterCard, Discover, American Express, Check or Cash.

• $30 fee will be added to accounts for any checks that are returned to us for non-payment.

• A $30 fee will be charged for any forms you bring into the office for the doctor to complete related to your treatment. You will receive your forms completed within 7 business days.

• We charge $25 for copying medical records according to *(*A.R.S. $12-2295)

We make every effort to accommodate our patients schedule when making an appointment, please be considerate in keeping your appointment. F**or appointments that are not canceled with at least 24-hour notice, a $25 No Show Fee will be added to your balance.** *W*e are contracted with many insurers and health plans. As a courtesy to you, we will bill your health plan and you will only be required to pay the authorized Co-Payment at the time of the office visit. For any Co-Pay or balance that is not paid-in-full at the time of service, a $1**0 administrative fee will be added to the account.** If you have insurance coverage with a plan that we do not have prior agreement with, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore our charges for your care and treatment are due at the time of service.

• All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the balance owed.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information please call Dr. Nicholas Jay at 623-209-2000. If Dr. Jay is unavailable, you may make an appointment with our receptionist to see him within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: **Fletcher Heights Chiropractic 20783 N. 83rd STE 110 Peoria, AZ 85382**

• I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient Name: _____ **Signature:** _____ **Date:**_____
Parent or Guardian _____**Signature:** _____ **Date:**_____
Witness Name: _____**Signature:** _____ **Date:**_____

Assignment of Benefits (Insurance):

I hereby authorize _____to pay directly to **Fletcher Heights Chiropractic**, all benefits which are otherwise payable to me for professional services I receive which are eligible for reimbursement under my current health care plan.

Patient Signature:_____ **Date:**_____

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Informed Consent to Care:

•You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

•Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well being.

•It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractor can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly careful and is estimated to be related in one in one million to one in two million cervical adjustments.

•It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

•I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every. possible complications to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for present condition and for any future condition(s) for which I seek chiropractic care from this office. You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making, informed choices. This process is often referred to as " informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives and the potential effect on your health if you choose not to receive the care

I understand that this office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgement that I have received a copy of (Practice Name) Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of this information to the doctor. I acknowledge that additional information published in government new letters regarding my rights is available to me upon request. I have been given the first two original pages of this 'Notice to keep. I do not have any question regarding my rights or any of the information I have received at this time.

Patient initials:_____ REGARDING NOTICE OF YOUR RIGHT TO PRIVACY AND CONSENT

Patient signature:_____Date:_____

Witness:_____Date:_____

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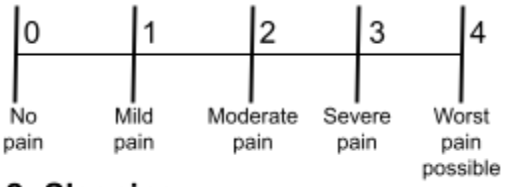
Functional Rating Index

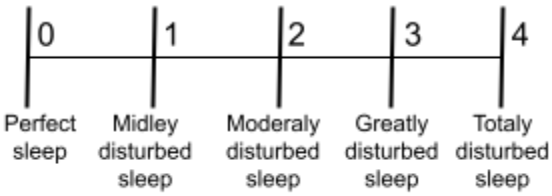
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

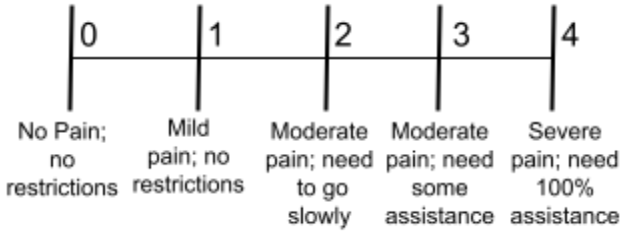
1. Pain Intensity



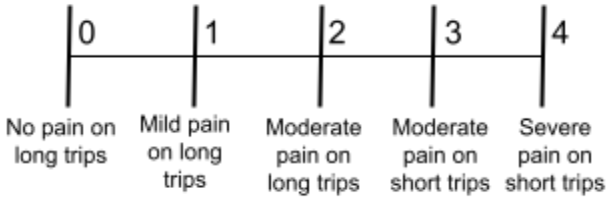
2. Sleeping



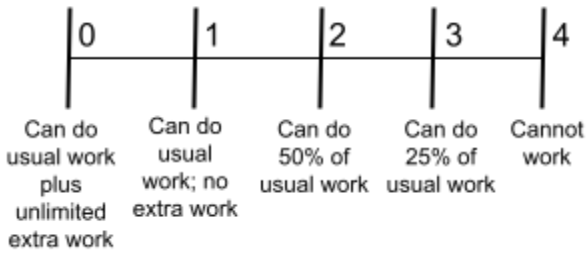
3. Personal Care (washing, dressing, etc.)



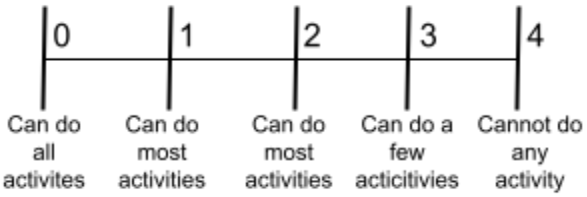
4. Travelling (driving, etc.)



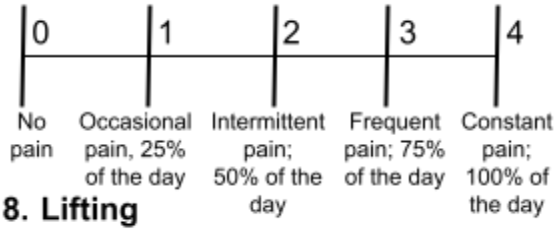
5. Work



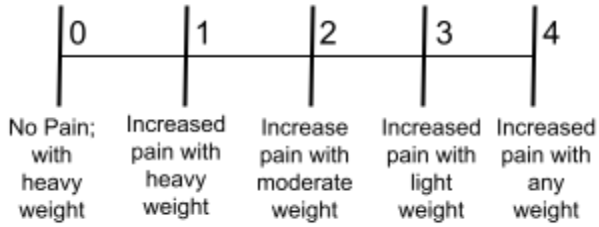
6. Recreation



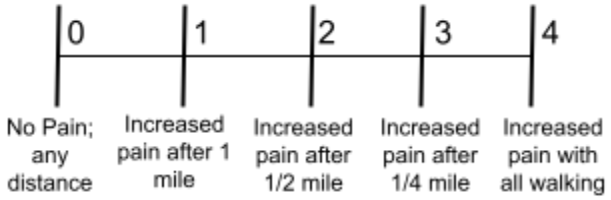
7. Frequency of Pain



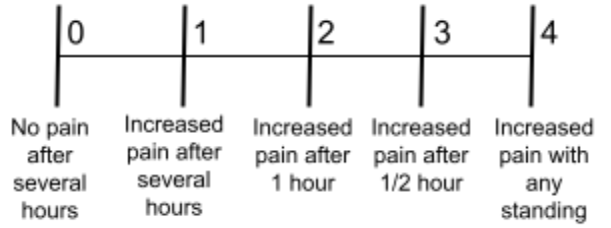
8. Lifting



9. Walking



10. Standing



Patient Signature _____

Date _____