MONARCH chiropractic

Thank you for choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you heal quickly and enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime. We look forward to helping you and your family members achieve your health goals.

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____ Referred by: _____

Name: _____

Cell Phone: _____ Home Phone: _____ Office Phone: _____

Email Address: _____

Address: _____ City: _____ State _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children_____

Occupation: _____ Years on Job: _____

Emergency Contact:

Name: _____ Phone Number: _____

Would you like Appointment Reminders? ❑ Text: please provide cell phone carrier: _____
❑ Email ❑ No Thanks

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____ Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Monarch Chiropractic may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Monarch Chiropractic's Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Monarch Chiropractic reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Monarch Chiropractic.

With my consent, Monarch Chiropractic may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Monarch Chiropractic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Monarch Chiropractic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Monarch Chiropractic may decline to provide treatment to me.

_____ _____

Signature Print Name

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature Date

Authorization to Pay/Release Is Granted to: **Monarch Chiropractic**

HEALTH STATUS & HISTORY

What is your **primary** complaint? _____

When did it first begin? Was it gradual or sudden? Is it getting better or worse? _____

_____

Is there anything that makes it better or worse? _____

_____

How would you describe it? _____

_____

Where did it first begin, and does it travel to any other regions of the body? _____

_____

On a scale where 0 is no pain, and 10 is the worst pain you've ever experienced, please rate your current pain level.

1 2 3 4 5 6 7 8 9 10

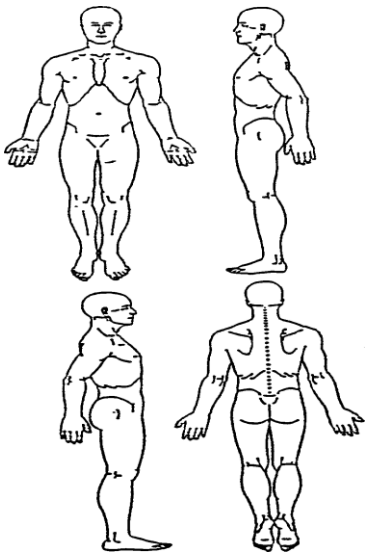
On the same scale, rate your pain at it's lowest point.

1 2 3 4 5 6 7 8 9 10

At its worst, how would you rate the pain?

1 2 3 4 5 6 7 8 9 10

Please mark the location of the problem, if you're having physical symptoms:



Stress level overall: Low Medium High Out of this world

Are you a smoker now? Y or N

List/Describe Other Current Health Problems:

1. _____ 3. _____
2. _____ 4. _____

Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking (prescription and over the counter)?

_____

_____

Injuries can cause serious spinal problems. Have you been injured in the past or recently (sports, work, car accidents, cumulative trauma)? If so, please list and give dates:

_____

_____

_____

Chiropractors are the only doctors trained to analyze, detect and correct Vertebral Subluxations (misaligned vertebrae causing Neurological Dysfunction, thus affecting how your body functions, heals and ages).
Vertebral Subluxations can happen in many ways. Please circle if you have had difficulties with any of the following:

Birth Process (Yours)	Auto Accidents	Trips, Falls
Birthing children (If you're a mom)	Work Injuries	Sickness, disease
Childhood Play	Environmental Toxicity	Other: _____
Growth Spurts	Sports Injuries	_____
Body Weight Changes	Intensive Training	

Are you experiencing difficulties with any of the following functions? Please circle Y or N, if Y, please explain.

Bladder/bowel function Y or N _____
Sleep Y or N _____
Energy Y or N _____
Concentration/Focus Y or N _____
Appetite Y or N _____
Digestion Y or N _____
Mood Y or N _____
Menstrual Cramps Y or N _____
Strength Y or N _____
Balance Y or N _____
Flexibility Y or N _____
Headaches Y or N _____
Allergies Y or N _____
Posture Y or N _____
Blood Pressure Y or N _____
Pain Y or N _____
Weight gain/loss Y or N _____
Vision Y or N
Memory Y or N
Patience Y or N
Sexual function Y or N
How much/quality sleep do you get per night? _____

As a result of Chiropractic Care, my goals are: _____

_____

_____

X-RAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

Patient Consent to X-Ray

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-rays.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_____ _____

Patient Signature Date

_____ _____

Witness Date

CONSENT FOR TREATMENT OF MINORS

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I (We) being parent, guardian or custodian of_____, a minor the age of _____, do hereby authorize, request and direct Dr. Reid Doyle to perform any exam, x-ray and Upper Cervical chiropractic treatment for their condition as he deems necessary.

_____ _____

Parent, Guardian or Custodian Date

FINANCIAL OFFICE POLICY

1. All patients are on a cash basis.

2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.

3. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.

4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.

5. As a patient, it is your responsibility to take care of the co-payment and any non-covered services on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.

6. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

7. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.

8. We will not enter into any dispute with your insurance company.
If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

9. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.

10. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.

11. This office accepts, MasterCard, Discover, Visa, Cash and Personal Checks.

12. Practice member understands that if they wish to stop care prior to utilizing all credits, clients account balance will be prorated based upon the full rate cash visit price per visit.

13. Practice members participating in the 12-month wellness plan who decide to terminate before their 12 months have been completed understand that one more monthly payment will be withdrawn before termination.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

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 an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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 complication 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 my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:

Parent or Guardian:_____ Signature:_____ Date:

Witness Name:_____ Signature:_____ Date:

CANCELLATION & NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if a cancellation is necessary, you provide more than 24 hour notice. This will enable a person on the wait list to be scheduled in that appointment slot.

Cancellations made with less than 24-hour notice are subject to a $60.00 cancellation fee, which is not applied towards your care plan. Patients who do not show up to their appointment will be considered a NO SHOW and will be subject to a $60.00 fee.

The Cancellation and No Show fees are the sole responsibility of the patient and will be charged to the credit card on file.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. In this instance, fees are subject to review by management and may be waived.

Monarch Chiropractic firmly believes that a good doctor/patient relationship is based upon clear communication. Thank you for your understanding and cooperation.

By signing below, I hereby state that I understand the cancellation & no-show policy:

Signature: _____ Date: _____

CREDIT CARD BILLING INFORMATION (OPTIONAL)

We can take information at time of payment if you prefer

CC# _____/_____/_____/_____ Expire date _____/_____ CVV#___ ___ ___

Card Type: Visa ☐ MasterCard ☐ Discover ☐ Debit ☐

Billing address _____

City_____ State_____ Zip code _____

Phone (_____)_____Email _____

Credit Card Holder Information

Full Name _____ Date of Birth: _____/_____/_____

Cardholder Signature: _____ Date: _____