HIGHPOINT
SPINE AND JOINT CENTER

PATIENT DEMOGRAPHIC SHEET

Thank you for completing this form, *our receptionist will assist you with all questions*. Your responses *will be kept confidential*.

First Name:

Middle Initial:

Last Name:

Mailing Address:

City:

State: **Zip Code**:

Cell Phone Number:

☐ OK to leave a detailed message ☐ OK to receive text message reminders

Home/Work Phone Number:

❑ OK to leave a detailed message

Email Address:

Date of Birth (mm/dd/yyyy):

Social Security Number:

Gender: ❑ Female ❑ Male

Race: ❑ White ❑ Black/ African American ❑ American Indian ❑ Alaskan Native ❑ Asian ❑ Pacific Islander/ Hawaiian Native ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino

Marital Status: ❑ Single ❑ Married ❑Divorced ❑ Widowed

Spouse's Name:

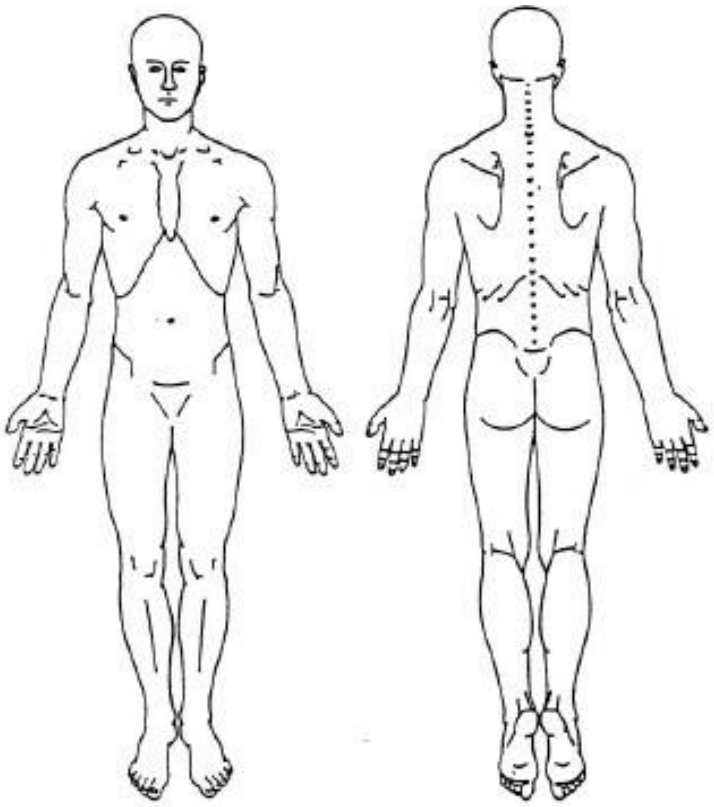
Employment Status: ❑ Full-time ❑ Part-time ❑ Not Employed ❑ Self-Employed ❑ Retired ❑Active Military

Employer's Name:

Emergency Contact?
Phone #

How did you hear about us?

Please circle painful areas:



Mechanism of Injury? _____

Intensity of the symptoms:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Symptoms improve with: sitting walking laying down standing rest ice heat medication other

Symptoms worsen with: sitting walking laying down standing rest ice heat medication other

Primary Physician: _____

Do we have permission to share information with your Physician?
Yes No

HIGHPOINT
SPINE AND JOINT CENTER

CONDITIONS OF CONSENT TO TREATMENT

1. **CONSENT** I hereby request and consent to medical or chiropractic care for the patient (and the patient's newborn child in maternity cases) including all routine examinations, tests, photographs and other procedures. Any tissue removed may be disposed of in the Clinic's customary manner. I acknowledge that no guarantees have been made as to the results of such clinic and medical care. I understand a patient has the right to refuse treatment and that my signature below is not a consent to any special medical or surgical procedure. In the event that such procedures are recommended, it is the physician's responsibility to explain the nature of the procedure, the reason it is recommended and the risks associated with the procedure. Patients are encouraged to insist on any additional information necessary to make an informed decision to consent to or refuse treatment. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.
2. **ASSIGNMENT OF BENEFITS** I hereby assign to the Clinic, for services provided by the Clinic, all coverage or other benefits available under any government program, insurance policy or plan, worker's compensation claim, and other benefit program, and I direct that all benefits be paid directly to the Clinic. I agree that the clinic and the physicians may receive benefits directly, which will discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient. These assignments may not be revoked as to services provided during this treatment.
3. **FINANCIAL AGREEMENT** I agree to pay promptly and fully all charges for services and supplies provided by the Clinic, Physicians and other health care providers, in accordance with their regular rates and terms. I hereby personally obligate the patient and myself, if signing as spouse of the patient or as parent of a minor patient, to pay off all such charges. No extension of forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges, shall waive or release these personal financial obligations. I understand that it is my responsibility to obtain any pre-certification approval required by my insurer, and to take all other steps to qualify for insurance coverage. An itemized statement is available upon request. I hereby give my express consent to Highpoint Health, LLC or any person, entity or organization working on behalf of Highpoint Health, LLC, including without limitation any vendor performing billing or collection services for Highpoint Health, LLC, to contact me regarding my account(s) with Highpoint Health, LLC regarding any amounts I may owe by telephone at any telephone number associated with my account(s), including wireless telephone numbers, which could result in charges to me. Such express consent includes, without limitation, contact including the use of prerecorded and artificial voice messages and/or use of an automatic dialing device, as applicable.
4. **MEDICAL RECORD RELEASE** I authorize release of all or any part of the patient's medical record to any person or entity which may be responsible to pay for any portion of the charges incurred. This release to third-party payers may not be revoked as to records of services provided during this treatment. I understand that the Clinic maintains medical records on an online computer system in order to make historic health information readily available to the patient's physicians for use in subsequent consultation and treatment. I authorize release at any time of medical records from this treatment to any physicians or other health care professionals (and their staff) who may require health information in connection with the patient's current or subsequent health care. This release to health care professionals may be revoked in writing to the Clinic, at any time.
5. **PERSONAL VALUABLES** The Clinic is not liable for any loss or damage to any money, jewelry, glasses, dentures, hearing aids, documents, or other articles of unusual value, which I chose to keep in my possession.
6. **EDUCATION** Highpoint Health, LLC is a clinical site for educational purposes and as such students may provide care under the supervision of their faculty members or sponsoring physician or staff members. You have the right to refuse care by students. It is your responsibility to advise your physician or care giver of your decision.

This form has been fully explained to me, I understand its content, and I have had a full opportunity to ask questions concerning this form.

Signed _X_____ Parent/Guardian/POA Printed Name _____

Date _____ Time _____ Relationship _____

Witness _____

HIGHPOINT
SPINE AND JOINT CENTER

Dr. Ryan M. Behrend, D.C.

Informed Consent

Nature and Purpose of Chiropractic

Adjustments are made by chiropractors to correct spinal and extremity joint dysfunctions. One of the most common disturbances to the musculoskeletal and nervous system is joint dysfunction. The condition exists where one or more vertebrae in the spine or bones in an extremity are misaligned or fixed in an improper position sufficiently to cause interference and/or irritation of the nervous and musculoskeletal systems. The primary goal of chiropractic healthcare is the removal of these joint dysfunctions. This is done with a chiropractic adjustment following an examination which may include physical and spinal examination, orthopedic and neurological testing, palpation, radiology examinations and laboratory tests.

In addition to adjustments or manipulations, physiotherapy and/or rehabilitative procedures may be included in the management protocol.

Material Risk Inherent to Chiropractic Healthcare

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintaining health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome (VAS) including stroke and perhaps, death through complicating factors. Risk associated with physiotherapy may include not only the foregoing but also allergic reaction and muscle and/or joint pain.

Probability of Risk

Fractures are rare occurrences that result from some underlying weakness in bone which can be checked for during the process of history, examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidents of stroke are exceedingly rare and are estimated by the latest literature to occur between one and one million and one in five million cervical adjustments. The other complications are generally described as rare.

Availability and Nature of Other Treatments

Other treatment option available for your condition may include:

1. Self-administered over-the-counter analgesics and rest.
2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.
3. Hospitalization
4. Surgery

Risk and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing function. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

ATTENTION: MEDICARE PATIENTS

THERE IS A $54.00 CHARGE FOR YOUR FIRST VISIT THAT MEDICARE OR YOUR SUPPLEMENT INSURANCE WILL NOT COVER. YOU WILL BE RESPONSIBLE FOR THIS CHARGE.

Authorization for Chiropractic Care and Treatment

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Patient/Parent/POA Signature: _____ Date: _____

HIGHPOINT
SPINE AND JOINT CENTER

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

PATIENT NAME _____

(Last) (First) (Middle)

MEDICAL RECORD# _____

□ I have received the Highpoint Health, LLC Notice of Privacy Practices.

_X_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Relationship to Patient

Employee: **Documentation of Good Faith Effort**

Give a reason if signed acknowledgement is not obtained:

□ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian decline to acknowledge the receipt of the Notice of Privacy Practices.

□ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian.

□ Other _____

_____ _____

Employee Date