Full Name (please print) _____Phone_____

Address_____City_____State_____Zip_____

Date of Birth_____ Gender M F SSN_____

Emergency Contact _____ Phone_____

Relationship to Patient _____

Please circle one if you would like to be sent a reminder for future appointments: Text Email

Email (Required): _____

How did you hear about our office? _____

Reason for your visit today? (Please list areas of pain) _____

Is your condition due to an accident? YES NO Date of your accident_____

Have you ever had any previous chiropractic experience? _____
Have you seen any other health care provider for the above complaint? _____
Have you ever served in a branch of the military? If YES what branch? _____

Consent for Treatment

I hereby consent to the performance of examination and treatment on myself or on _____ by Dr. Lindsey Rovenstine. I further understand that there can be risk associated with chiropractic care, which includes but not limited to fractures, sprains/strains, strokes and disc injuries. I am, therefore, willing to accept and consent to the risk associated with care currently and in the future. Furthermore, any risk involved with chiropractic care will be explained upon request.
NOTICE: Our office often utilizes an open area for treatments, adjustments, and physical therapy. This may result in some of your care or discussions with the doctor being overheard by other patients and staff. All necessary actions will be taken to prevent or limit this during the history and review of the patient's confidential information. If you have any concerns about your privacy, please bring it to the doctor's attention immediately. This notice of privacy and open bay notice is effective as of February 17, 2014. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature below acknowledges that I had the opportunity to read this notice and hereby agree to its terms. I (we) hereby authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider, or attorney in order to process any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

X Patient Signature _____Date_____

Guardian Signature_____Date_____

I attest to the information below to be correct. Patient denies any other past illnesses, hospitalizations or surgeries. I further understand that any charges incurred in the office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

X Patient Signature: _____Date_____

When did your pain start? _____ HOW DID IT HAPPEN? _____

Where is the pain located? _____How frequent is this condition? _____

On a scale of 0-10 (0 is no pain - 10 needs to go to ER) what is your pain currently? _____

What is your pain at its worst? _____What is your pain at its best? _____

Describe the pain: **Sharp Dull Numbness Tingling Aching Throbbing Burning Stiff/Tightness Stabbing**

Does your pain travel? If so where? Down into your arms and hands or legs and toes? _____

What makes the problem worse? **Standing Sitting Bending Lifting Twisting Other**_____

Do you have any pain when coughing, sneezing, laughing, or going to the bathroom? _____

Do you have any weakness in your arms, hands, fingers, in your legs, feet or toes? _____

Any difficulty controlling bowel or bladder? ___ **YES ___ NO**

Does your pain wake you up at night? ___ **YES ___ NO** In what position do you sleep and how well? _____

What makes your pain better? _____

Have you had any recent weight gain or loss? ___ **YES ___NO**

Have you had a fever recently? ___ **YES ___ NO**

Have you ever had x-rays, MRI, or CAT scan of your body? ___ **YES ___ NO** When? _____

(FEMALE) is there any possibility you are pregnant? ___ **YES ___ NO ___ MAYBE**

(MALES) Have you ever had any prostate problems? ___ **YES ___ NO**

Please list all the different doctors and their specialties you have seen in the last 3 years.

Is there any family history of serious illnesses? Cancer, heart disease, etc. If yes, please describe_____

Have you had any of the following: Stroke, Aneurysm, Heart Disease, Kidney Disease, Liver Disease or Lung Disease?

Please list all medications (prescription, non-prescription, and vitamins) _____

Do you have a history of cancer, high blood pressure, shingles, diabetes or any other serious illness? _____

Have you ever been diagnosed with a spondylolisthesis, compression fracture, spinal fracture or osteoporosis? _____

Please list any surgeries, major traumas, (including concussions and broken bones) illnesses, recent immunizations, car accidents or hospitalizations and dates._____

- Providers notes: BP_____/_____ Pulse: _____
- Additional Notes:

  _____

  _____

  _____

  _____

  _____

Financial and Appointment Cancellation Policy

We strive to render excellent care to you and the rest of our patients. Your care and treatment are a priority to us. We also ask that you respect our physician's time and expertise as well. In an attempt to be consistent with this, we have an appointment cancellation policy that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor's time.

Our policy is as follows:

I (patient, guardian, or legally authorized individual) am aware that I am financially responsible for all outstanding balances due to Crossroads Chiropractic. All outstanding balances due to our office should be paid in a timely manner. You (patient, guardian, or legally authorized individual) will have 60 days after being sent first bill before late fees will apply. All unpaid balances will be sent to collections. If you need to make payment arrangements, please contact our office or let our staff know.

We (Crossroads Chiropractic) request that you (patient, guardian, or legally authorized individual) give 24-hour notice in the event that you cannot make it to your scheduled appointment. If you miss an appointment without contacting our office or reschedule or cancel an appointment with less than 24-hour notice, it is considered a "missed" or "no show" appointment. YOU WILL BE CHARGED $25.00 FOR THE VISIT YOU WERE SCHDULED FOR. In order to make another appointment you will need to settle your account prior to your next visit or for both visits prior to leaving your next adjustment. Additionally, if you are 10 or more minutes late for an appointment, it will be considered a "missed" or "no show" appointment, and that appointment will need to be rescheduled. Also, if you miss 3 or more appointments, Crossroads Chiropractic reserves the right to discharge you from the practice for failing to follow treatment recommendations.

You may contact the office via phone or email. Phone is preferred. Please see our business card with all our contact information.

If you have any questions regarding this policy, please let our staff know, and we will be happy to clarify the policy for you.

We look forward to being a continued part of your wellness.

I have read and understand the Financial and Appointment Cancellation Policy of Crossroads Chiropractic and I agree to be bound by its terms. I am aware that I must pay outstanding balances prior to making a new appointment or as otherwise worked out by staff.

X _____ _____

Patient or Legally Authorized Individual Signature — Date

X _____

Print Patient's Full Name

_____

Witness Signature

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **CROSSROADS CHIROPRACTIC** or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created or received by this office. I understand that a copy of the Notice of Patient Privacy Policy is available upon request, and I can request this at any time.

X _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Occasionally we have an open treatment area, but upon notification private areas are available.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

X _____ _____

Patient or Legally Authorized Individual Signature — Date

X _____ _____

Print Patient's Full Name — Time

_____ _____

Witness Signature — Date