Chiropractic
Stepping up your health
Salem Freeman

INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of rehabilitation and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future work at Salem Chiropractic Clinic/Freeman Chiropractic Solutions.

I have had an opportunity to discuss with the doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of Chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to Chiropractic treatments. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (print)_____

Patient/Guardian Signature_____ Date _____

Relationship to patient _____

CONSENT TO TREATMENT OF MINOR CHILD

Salem Chiropractic Clinic & Freeman Chiropractic Solutions

I hereby authorize:

Dr. Debra Cheeseman or Dr. John Bosch and whomever they designate as assistants at the Salem Chiropractic Clinic or Freeman Chiropractic Solutions to administer chiropractic care as deemed necessary to my _____(indicate relationship of child), _____ (name of child) for this visit and any other future visits.

I also understand that our clinic requires a parent or legal guardian to accompany the minor patient at all times during their treatments, except in emergency situations or if they sign a waiver state to do so otherwise. (Please place a check mark in the circle below to indicate your request for your child's care at our clinic.)

- I **do not authorize** my child to be treated at this clinic without any parent or legal guardian with them. (This also means that siblings or grandparents are not able to bring them.)
- I **do authorize** my child to be treated at this clinic without any parent or legal guardian with them. (This means that a minor child can come on their own or have any other adult with them.)

Signature of the Parent or Guardian: _____

Date: _____

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Youth Fee Policy

At Salem Chiropractic Clinic/Freeman Chiropractic Solutions, we promote and feel passionately that children benefit from chiropractic care and that this enhances their present and future health. Treating our youth reinstates the belief of the importance of correcting small problems before they become larger problems in their adult life.

Because we strongly encourage youth (ages 0-18) to stay healthy with chiropractic care, we have developed two options to choose from.

Option 1 - Billed charges

Billing to a guardian or to insurances (including Aflac or other accident policy).

- Chiropractic treatments are $45.00 or $51.00 depending on the level or care
- Therapies are $19.00 or $20.00

Option 2 – Time-of-service

Payment is due the day of treatment and needs to accompany the patient.

- Chiropractic treatments are $35.00
- Therapy charges are $10.00
- No insurance may be billed, including Aflac or other accident policy

We strongly encourage parents to fill out the payment authorization form to take full advantage of this time-of-service discount. If payment does not accompany the youth, normal charges will be charged.

Other charges including x-rays and evaluations will be normal fees.

PATIENT REGISTRATION FORM Date: _____

Patient Contact Information

First Name	***Middle Initial***	***Last Name***	
Date of Birth	***Social Security Number***	***Sex*** ☐ ***Female*** ☐ ***Male***	***Age***
Street Address and PO Box(if you have one)			
City	***State***	***Zip Code***	
Home phone	***Work Phone***		
Cell Phone			
Email Address			
Place of Employment and Occupation			
Status(circle one) ****Single*** ****Married*** ****Partnered*** ****Widowed*** ****Separated*** ****Divorced***			

1. **Preferred Language:** _____
2. **Race (circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer
3. **Ethnicity (circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to answer
4. **Tobacco Status:** **NEVER:** Smoker / Chewer
   FORMERLY: Smoker / Chewer
   CURRENTLY: Smoker / Chewer
   If you are currently a smoker, how often? **Light** (1-9 cig./day) **Moderate** (10-19 cig./day) **Heavy** (20-39 cig./day)

Spouse, Guardian or Emergency Contact:

Full Name and Relationship			**Address (if different)**
Home Phone	**Cell Phone (Guardian 1)**	**Cell Phone (Guardian 2)**	**Work Phones for Spouses and Guardians**
Do you want these numbers as your emergency contact? YES NO **If no please fill out the information below.**			
Full Name and Relationship			
Complete Address and Phone Numbers			

How did you hear about our office? _____

_____

Dr. Debra Cheeseman
Dr. John Bosch

Salem Chiropractic Clinic
Stepping up your health
& Rehabilitation

740 South Main Street
PO Box 59
Salem, SD 57058
605-425-2754

Patient Information:

Name: Date:

Health Complaints:

What is your ***primary*** complaint?

_____

_____

How does the ***primary*** complaint feel? (**Circle all that apply)**

Dull/Achy Sharp Numb Tingling Burning Cold

Other: _____

How often do you experience the ***primary*** complaint? **(Circle what applies)**

Constantly Daily Weekly Monthly Yearly Other: _____

What caused your ***primary*** complaint? _____

_____

Was it an injury? _____ Date of Injury? _____ Did it happen at work? _____ If so, have you reported it? _____ Will this be work comp? _____

Have you been seen by any other chiropractor, medical doctor, or other healthcare professional for this condition?

_____

What makes the condition worse? **(Circle all that apply)**

Sitting Standing Bending Lying Walking Other: _____

_____

What makes the condition better? **(Circle all that apply)**

Sitting Standing Lying Walking Ice Heat Other: _____

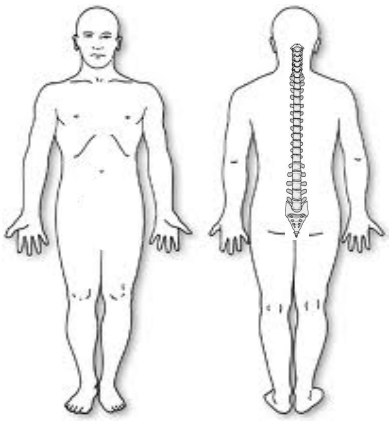
_____

Using the scale on the back of this clipboard, rate how your ***primary*** complaint affects your life. **(Circle a number)**

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Severe pain Very Severe Worst Possible

Please mark all the areas you are having pain on this diagram to the right:



Office Use Only

Height: _____ Pulse: _____

Weight: _____

Blood Pressure: _____

Family History:

Please write in the space (M) for Mother, (F) for father, (B) for Brother, & (S) for Sister.

Diabetes: _____ Heart Problems: _____

Kidney Problems: _____ Cancer: _____

Back Problems: _____ Major Illness: _____

Personal History: **Circle all that apply**

Diabetes **Heart Problems** **Kidney Problems** **Cancer** **Back Problems**

Any other major illnesses or medical conditions: _____

_____

_____

List any Surgeries: _____

_____

List all medications or vitamins (prescription & over the counter) and the reason for taking them:

_____

_____

_____

_____

List all allergies to any medications:

_____

_____

_____

_____

_____

Working conditions: **Sitting** **Standing** **Lifting** **Walking** **Other: _____**

_____

Exercise & other activities. How frequent?

_____ _____

_____ _____

Past Injuries:

Car Accidents: Be sure put the dates of the accidents.

_____

_____

_____

_____

_____

Falls or Other Injuries: Be sure to put the dates of the Injuries.

_____

_____

_____

_____

Were X-rays or MRI of the injured area taken within the last 5 years? _____

What Clinic or Doctor? _____

When was the last time you saw a chiropractor? Doctor, Date and Office? _____

Patient's Name_____ Date of Birth: _____

Account Information

Name of person responsible for this account? ☐ Self ☐ Other: _____

Date of Birth of responsible party if not self _____

Benefits Assignment

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. **All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy.**
2. **Amounts owed on my behalf from proceeds of any settlement related to my case.**

Information Release

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

I understand and agree to the following:

1. There is no guarantee that my health insurance plan or policy will pay for all or part of my care. It is a courtesy that we submit to your insurance, I understand that I am responsible if the insurance claim is denied.

2. I will be informed of fees and charges before the associated procedure or service is performed.

3. As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered.

Patient's or Guardian's Signature: _____Date: _____

Notice of Privacy Practices Patient Acknowledgement HIPAA Policy

The undersigned does hereby acknowledge that he or she has been offered/received and understand a copy of this office's Notice of Privacy Practices Pursuant to HIPAA. He or she has also been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right, how I may exercise these rights, and the practice's legal duties with respect to my information.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Patient Name: _____ Date: _____

Signature of patient or guardian as defined by State Law: _____

Relationship to patient: _____

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