# Dillon/Farrar Chiropractic
A Health and Wellness Center

**Name** _____ _____
First Middle Initial Last **Today's Date**

**Address** _____
Street City State Zip

**Date of Birth** _____ **Age** _____ **Social Security #** _____ **Sex:** ☐ **Male** ☐ **Female**
mm/dd/year

**Primary Phone #** _____ **Cell #** _____ **Email**_____

**Emergency Contact** _____ _____
Name Number

**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Partnered**

**Your Occupation**_____ **Employer** _____

**Spouse's Name** _____ **Number of Children & Ages** _____

**Primary Insurance Co:** _____ **Secondary (if applicable)** _____

**Subscriber Full Name** _____ **Date of Birth** _____

**Relationship to Subscriber:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

**Name of Primary Care Physician (PCP)** _____ **Phone #** _____

**How did you find out about us?** _____

**Authorization to Release Medical Information**
I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance and personal information given to this clinic is correct and complete.

**Patient Signature**_____ **Date**_____

**To be filled out in office only:**
**Notice of Privacy Practices**
I have read and understood the Notice of Privacy Practices given to me by Dillon/Farrar Chiropractic.
I have received a copy of this notice _____ I refused a copy of this notice _____

_____ _____
Signature of Patient/Legal Guardian Date

**Symptoms/Condition**

Major Complaint _____

How and when did the pain/problem start? _____
How frequently do you suffer from it? □ Constantly □ Frequently □ Intermittently □ Occasionally
Does the pain radiate? □ Yes □ No
What activities aggravate your condition/pain? _____
What activities relieve your condition/pain? _____
Is the condition worse during certain times of the day? _____
Is the condition interfering with □ Work □ Sleep □ Routine □ Other _____
Is the condition getting progressively worse? □ Yes □ No
Other doctors seen for this condition? _____
Any home remedies? _____

**Other symptoms: (Check all that apply)**

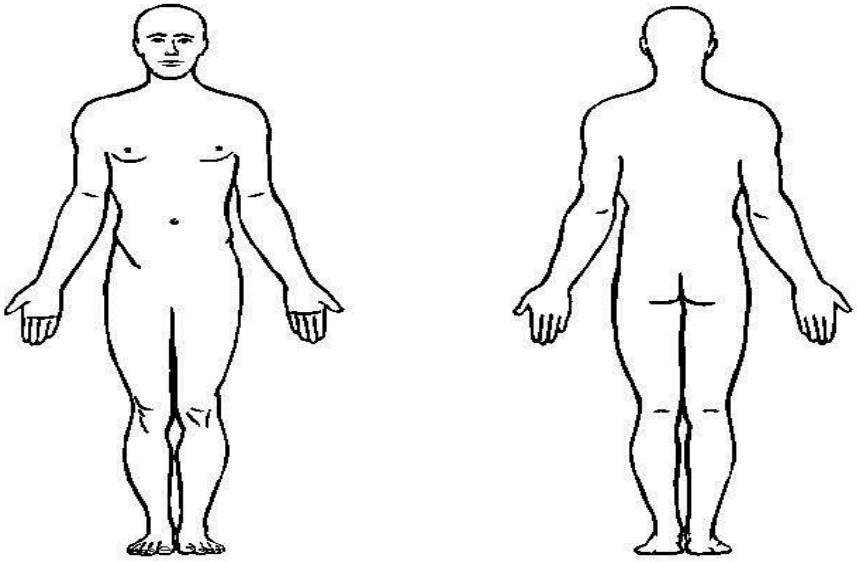
| | | | | | |
|---|---|---|---|---|---|
| □ Headaches | □ Neck Pain | □ Sleeping Problems | □ Back Pain | □ Nervousness | □ Tension |
| □ Irritability | □ Chest Pain | □ Dizziness | □ Stiff Neck | □ Fatigue | □ Depression |
| □ Fever | □ Fainting | □ Diarrhea | □ Constipation | □ Memory Loss | □ Light Sensitivity |
| □ Ears Ring | □ Loss of Smell | □ Loss of Taste | □ Balance Loss | □ Hands Cold | □ Feet Cold |

□ Pins & Needles in Legs □ Pins & Needles in Arms □ Numbness in Fingers □ Numbness in Toes
□ Shortness of Breath □ Cold Sweats □ Stomach Upset

**Please use the diagram below with appropriate symbols to indicate where your complaint is located.**

| | |
|---|---|
| **///** | **Sharp Pain** |
| **ZZZ** | **Stiffness** |
| **+++** | **Dull, Achy Pain** |
| **000** | **Pins & Needles** |
| **===** | **Numbness** |
| **XXX** | **Burning** |

**Office Use Only**:
*BP:* _____/_____
*Temp:* _____
*Weight:* _____
*Height:* _____



***For your current condition**

Have you been under drug/medical care? _____
What medications are you taking for this? _____ How Long? _____
Have you had surgery? □ Yes □ No What surgery? _____
When?_____

**Rate using the following scale**

**No Pain** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **The Worst Pain Ever**

**Health History**

Yes No

□ □ Have you seen a chiropractor before? _____

□ □ Did/Do you smoke? _____ □ Alcohol? _____

□ □ Diet (Do you eat healthy foods)? _____

□ □ Have you been in accidents? _____

□ □ Have you had surgery? _____

□ □ Drugs? Prescriptive and Non-prescriptive? _____

□ □ Jaw/Teeth Problems? _____

□ □ Eye Problems? _____

□ □ Hearing Problems? _____

□ □ Exercise Regularly? _____

□ □ Did/Do you have occupational stress? _____

□ □ Physical Stress? _____

□ □ Mental Stress? _____

□ □ Hobbies/Sports Injuries? _____

□ □ Other traumas or problems? _____

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most *recent* layer of Spinal and Neurological Damage (Vertebral Subluxation Complex). This care usually reduces or eliminates the symptoms. Then **Reconstructive Care** begins which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care.** All of these options will be explained at your Doctor's Report. Then you'll be able to begin a course of care that fits your health goals.

Patient Signature _____ Date _____

**For Provider Use Only**

Postural Findings _____

Health Goals _____

Bilateral Scales- Left is _____ Right is _____

Traumas 1. _____2. _____ 3. _____ 4. _____

NOTES:

## Terms Of Acceptance and Consent

With any type of treatment outside of our office, there are potential risks associated with the delivery of treatment. Chiropractic care is no different. Therefore, it is necessary to inform you of such risks prior to initiating care. While chiropractic care is a remarkably safe form of treatment, we want you to be fully informed before consenting to chiropractic care at our office.

We **DO NOT** diagnose or treat any disease, nor do we promise a cure for any symptom or condition you are experiencing. We **DO** promise to provide you with the very best care of care. If the doctor determines that your condition cannot be helped with chiropractic care or is outside of the chiropractic scope, then you will be referred to an appropriate medical doctor. Our primary goal is to remove any interference, as best as possible, of the nervous system that may be occurring at the spinal level, or a specific joint, and manifesting as the primary factor or contributing factor to the symptom(s) you are experiencing. We will utilize a chiropractic adjustment and any therapies deemed appropriate to address the nerve inference. We will also present a treatment plan for ongoing care to resolve your health issue as best as possible.

**Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or immunosuppressant medications prior to the treatment.**

**Specific Risk Possibilities Associated with Treatment**
**Soreness**- Chiropractic adjustments, physical therapy, and massage are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to treatment. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
**Soft Tissue Injury** – Occasionally treatments may aggravate soft tissue conditions temporarily. They can also cause minor ligament, tendon or muscle soft tissue injuries as well as bruising.
**Rib Injury**- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.
**Physical Therapy Burns**- heat generated by physical therapy modalities may cause minor burns to skin. These are rare, but if it occurs, you should report it to your doctor.
**Stroke**- Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 4 million upper cervical adjustments.

If you have any questions concerning this for or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic care treatment administered. I also authorize Dr. Brian Dillon or Dr. Farrar as well as any hired or contracted Doctor, assistant/therapists to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as necessary.

Patient Signature _____Date _____

### CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic Care.

Signature _____Date_____

### PREGNANCY RELEASE- FOR WOMEN ONLY

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of late menstrual period: _____

Signature _____Date_____

# PATIENT FINANCIAL AGREEMENT AND AUTHORIZATION

**Patient Responsibility**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree all services rendered to me are charged directly to me. I also understand and agree I am personally liable for payment for all services rendered to me.

I understand and agree Dillon/Farrar Chiropractic as a courtesy, shall prepare necessary reports and/or forms to assist me in collecting money from the insurance company. I also understand and agree Dillon/Farrar Chiropractic as a courtesy, may submit claims on my behalf.

If I am in receipt of any insurance payment regarding services rendered to me from Dillon/Farrar Chiropractic, I shall immediately forward the payment to Dillon/Farrar Chiropractic for posting to my account balance. I authorize my insurance company to forward payment for services rendered to Dillon/Farrar Chiropractic on my behalf.

**24 Hour Cancellation or Change of Appointment**

At Dillon/Farrar Chiropractic, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy email reminder 1 day prior to your appointment. If you find that you cannot keep your appointment we ask for a notice of at least 24 hours so we can assist other patients during that time. If you are unable to give us a 24 hour notice, we ask that you call as soon as you are able.

**Co-pay, Co-insurance, and Deductibles**

If you have a co-pay, co-insurance, or deductible with your insurance, you are required to pay that fee at the time of service. **We will give you the estimated cost each visit. You are responsible for any difference reported by the insurance company.**

**Termination of Care**

I understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable to Dillon/Farrar Chiropractic. If I do not pay in a reasonable amount of time, I understand and agree I will be responsible for costs of collections, reasonable attorney fees and court costs.

**Returned Check and Collections**

I will be responsible for a return check fee of $30.00 if the payment is returned for non-sufficient funds or account closed. Our office will make reasonable financial arrangements to help you pay for your care as well as have the opportunity to receive it in a timely manner. After 90 days, if no payments or arrangements have been made we have the right to forward your account to collections.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (Print) | Patient Signature | Date |