Grace Chiropractic
Dr. Andrea Rathbone
315 S Church St Suite C
Hendersonville, NC 28792
(828) 435-2377

Patient Information:

Today's Date ______________________ Birthday ____________________ Sex ◯Male ◯Female

First Name ______________________ Middle Name ____________________ Last Name ________________________

Married/Civil Union: ◯ yes ◯ no Spouse Name: ____________________ # of Children: ______ Height: _____

Home # ____________________ Cell # ____________________ Weight: _____

Address ____City/State/Zip____

Emergency Contact and Relation ____________________________ Emergency Phone _________________________________

Email ____

Occupation ______________________ Employer ____________________ Student? ◯Full time ◯Part Time

Reason for this Visit:

How did you hear about us? ____

Describe the reason for this visit____

____

When did this concern begin? ____________________ Has this concern: ◯Gotten Worse ◯Stayed Constant ◯Come and Gone

Does this concern interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Other Activities____________________________________

Has this concern occurred before? ◯ Yes ◯ No Briefly Explain: ____

Have you seen other doctors for this concern? ◯ Yes ◯ No Doctor's name: ____________________________________

Type of Treatment: ____

Have you been adjusted by a chiropractor before? ◯Yes ◯ No If yes, Why? ____

Doctor's Name: ______________________ Approximate Date of Visit: ____________

Personal Incident History:

Broken Bones:	Yes ☐	No ☐	Treatment:	Yes ☐ No ☐	Explain: ________________________	
Surgery:	Yes ☐	No ☐	Treatment:	Yes ☐ No ☐	Explain: ________________________	
Hospitalized:	Yes ☐	No ☐	Explain: ____			
Struck Unconscious:	Yes ☐	No ☐	Explain: ____			
Auto Accident:	Yes ☐	No ☐	Treatment:	Yes ☐ No ☐	Explain: ________________________	
Cancer:	Yes ☐	No ☐	Type: ____________________________			Year: __________________
Stroke:	Yes ☐	No ☐	Explain: ____			
Heart Attack:	Yes ☐	No ☐	Year: __________			
Pacemaker:	Yes ☐	No ☐				

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Health Checklist: *please check any symptoms/conditions you currently have and put a "P" beside any conditions you have had in the past that are resolved.*

☐ Headaches	☐ High cholesterol or triglycerides		☐ Scoliosis
☐ Dizziness or vertigo	☐ Heart murmur	☐ Food sensitivities	☐ Fibromyalgia
☐ Lethargy/weakness	☐ Varicose veins	☐ Celiac disease	☐ Anemia
☐ Recent weight loss or gain	☐ Coronary artery disease	☐ Crohn's disease	☐ Blood clots
☐ Eye/vision problems	☐ Asthma	☐ Irritable bowel disease	☐ HIV/AIDS
☐ Glaucoma	☐ Emphysema	☐ Poor balance	☐ Seasonal allergies
☐ Hearing problems	☐ Sleep apnea	☐ Numbness or tingling	☐ Alzheimer's disease
☐ Ringing in the ears	☐ Tuberculosis	☐ Tremors	☐ Suicidal thoughts
☐ TMJ problems	☐ Nausea or vomiting	☐ Anxiety and/or panic	☐ Chemical dependency
☐ Psoriasis	☐ Constipation	☐ Depression	☐ Diabetes *type I or II?* ______________
☐ Easy bruising	☐ Heart burn	☐ Sleeping issues	☐ Thyroid problems *explain:* ________
☐ Chest pain or tightness	☐ Hemorrhoids	☐ Muscle weakness	☐ Incontinence
☐ Shortness of breath	☐ Hepatitis	☐ Loss of smell or taste	☐ Kidney stones
☐ Palpitations	☐ Gallbladder problems	☐ Arthritis where? ____	
☐ High blood pressure	☐ Pancreatitis	☐ Osteoporosis	☐ Autoimmune disease: ______________

For Women, Only:

Are you taking birth control?	◯ Yes ◯ No	Do you have breast implants?	◯ Yes ◯ No
Do you experience painful periods?	◯ Yes ◯ No	Do you have irregular cycles?	◯ Yes ◯ No
Do you have endometriosis??	◯ Yes ◯ No	Menopause?	Yes. ◯ No ◯
Are you pregnant?	◯ Yes ◯ No	If so, what is your due date? _____________________________	

Family Health History:

Does anyone in your immediate family (parents, grandparents or siblings) have a history of cancer, diabetes, hypertension, strokes or other serious illnesses? If so, please list their relationship to you as well as the condition.

Current Medications ____

Medication Allergies____

____

Smoking Status: ☐ never smoked tobacco ☐ ex-smoker ☐ current someday smoker ☐ current every day smoker

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I certify that I'm the patient or legal guardian listed above. I have read/understand and included information and certify it to be true to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature ____ Date _____________

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Grace Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:
The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance. Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered or approved by their insurance plan. Copays are due at the time of service. Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

Missed Appointment Policy: Our policy is to charge **$60.00** after **one** missed appointment not cancelled at least **24 hours in advance**. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**. If you "no show" or "late cancel" to 3 appointments we have the right to dismiss you from our practice for non-compliance.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $35.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Signature ____ Date _____________

Printed Name ____

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Right to File a Complaint

You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Dr. Andrea Rathbone**

Address: **315 S Church Street Suite C Hendersonville, NC 28792**

Telephone No.: **(828) 435-2377**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. Grace Chiropractic reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Signature ____ Date ____________

Printed Name ____

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Informed Consent Form

PATIENT NAME: ____________________________________ DATE: ___________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign. A copy will be provided to you upon request.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- muscle strength testing
- basic neurological testing
- postural analysis
- electrical stimulation
- Active Release Techniques (ART) and Instrument Assisted Soft Tissue Mobilization

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare

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and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

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

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks 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 mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Andrea Rathbone* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _______________

____

Patient's Name

____

Signature or Signature of Parent or Guardian (if a minor)

Dated: _______________

Andrea Rathbone, D.C.

Doctor's Name

____

Signature