ACTIVE CHIROPRACTIC

Dr. Anthony Cutting

Name_____ Sex M F Date_____

Address _____City_____State _____Zip _____

Home Phone_____Cell Phone_____Work Phone_____

Date of Birth_____ Age_____ Social Security # _____

Email _____Referred by_____

Occupation _____ Employer _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary Reasons For Seeking Chiropractic Care:

Primary reason: _____

Secondary reason: _____

2. Chief Complaint: _____

Location of complaint: _____

Complaint began when and how? _____

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Yes No

Where? _____

Do you have any numbness or tingling in your body? Yes No

Where? _____

Grade intensity/severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous Interventions, Treatments, Medications, Surgery, or Care You've Sought For Your Complaint: _____

_____

4. Past Health History:

Previous illnesses you've had in your life: _____

_____

Previous injury or trauma: _____

_____

Have you ever broken any bones? Yes No

Which? _____

Allergies/Sensitivities _____

Medications and Supplements:

_____

_____

_____

Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

5. Family Health History:

Health conditions in immediate family: _____

_____

6. Social History:

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the carrier and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.
As a courtesy to you we will verify your health care benefits for this office. You will then be responsible for any co-pays and deductibles.

Your health insurance is a contract between you and the insurance carrier. In the rare event that your insurance company is in bad faith and after our office makes every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.
If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.
If collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees and other costs associated with collecting this balance. I hereby authorize the doctor and staff to administer treatment, physical examination, x-rays studies, chiropractic care and/or any clinic services that he/she deems necessary in my case. I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical services companies, welfare funds or the patients employer.

Signature_____ Date_____

Parent or Guardian Signature _____Date _____

ACTIVE CHIROPRACTIC, LLC

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments, chiropractic manipulative treatments) and any other associated procedures; physical examination, test, diagnostic x- rays, physiotherapy, acupuncture, physical medicine, physical therapy procedures, etc. on me by Anthony Cutting, DC and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications that may arise during treatment. Those complications include but are not limited to: fracture, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that results are not guaranteed.

I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed Name: _____

Signature: _____ Date: _____

If patient is a *minor*, please provide parent or guardian's information.

Name: _____ Relationship: _____

Parent or Guardian signature: _____

ACTIVE CHIROPRACTIC, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.
Signature: _____ Date: _____

If patient is a *minor*, please provide parent or guardian's information.
Name: _____ Relationship: _____

Parent or Guardian signature: _____

CANCELLATION/MISSED APPOINTMENT POLICY

Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require at least 24 hours advance notice if you need to cancel your appointment. For all missed or cancelled appointments with less than 24 hours notice, you will be charged a $ 75.00 cancellation fee. Appointment reminder calls/emails are a courtesy. Should you not receive a reminder telephone call/email, it is still your responsibility to remember your appointment.

I have read and understand the cancellation/missed appointment policy.
Signature: _____ Date: _____

If patient is a *minor*, please provide parent or guardian's information.
Name: _____ Relationship: _____

Parent or Guardian signature: _____