Janes Spinal Care

LTD Chiropractic LLC

New Patient Information Packet

Please complete all enclosed forms and present your driver's license/picture ID.

How did you hear about Janes Spinal Care?

Referred by: _____

What is the main complaint that brought you to the office today?

_____

_____

Personal Information

Last Name: _____ First Name: _____ Middle Name:
Today's Date: ____/____/_____
Address: _____ City: _____ State: _____ Zip:
Home Phone: (____)___-_____ Work Phone: (____)____-_____ Cell Phone: (____)____-
Date Of Birth: ___/___/_____ Age: _____Gender: □Male □Female
Email:_____

Emergency Contact
Name: _____ Relationship to Patient:
Home Phone: (____)____-_____ Work Phone: (____)____-_____ Cell Phone: (____)____-

NEW PATIENT INVESTMENT

New Patient FIRST VISIT

- Health History & How I Can Help You Consultation
- Spinal Examination (Includes Range of Motion and Muscle Testing)
- Neurological Examination
- Postural Screening
- Infrared Computerized Thermography Spinal Graphs
- Spinal Imaging

SECOND VISIT (Correction of the Misalignment)

- Report of Findings / Doctors Report
- Spinal Imaging Study and Analysis
- Spinal Adjustment / Correction

THIRD VISIT (Post Correction Check-Up)

- Spinal & Neurological Examination
- Care Plan

TOTAL INVESTMENT TO START CARE

$735

THIS IS THE SUM OF ALL OF THE ABOVE COSTS FOR YOUR FIRST 3 VISITS

Fees begin when a spine or spinal related problem is found and you decide to have us take care of it for you. Services other than those provided on routine office visits may be charged separately. Please note that fees are subject to change without notice (routinely increased annually). **There is no fee for consulting with the doctor to see if he can help you.**

Signature Date

*Signature of Parent/Guardian is required if patient is under the age of 18.

HIPAA – Health Insurance Portability and Accountability Act

The following is an explanation of our Privacy Policies for this office.

- Our office does NOT distribute or make available to any outside source your private personal health information.
- Your information is secure and is used only in submitting claims to third party carriers for payment of services.
- Our office is set up as an open adjusting environment. If a matter of privacy arises, please ask for the door to be closed.
- Our office may send you seasonal cards or birthday cards.
- Our office may call you to confirm or reschedule an appointment if necessary.
- A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our policies is available for you to read and have a copy for yourself. Please ask the front desk for it.

By signing, I have read, understand and agree to the privacy policies for this office. I can take a copy for my records. I understand that if I choose not to participate that I can and will notify Janes Spinal Care staff of my concerns in writing.

Signature Date

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concern itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.
Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name Signature Date

Consent to Evaluate and Adjust a Minor

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care. I also give my consent for films of my child, if applicable.

_____

Signature Date

Radiology Consent

I, _____, give the doctors of Janes Spinal Care my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office. I also understand that the x-rays will remain property of this office, where they may be seen at any time as required by federal law.

_____

Signature Date

For Women Only: Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual cycle: _____

_____

Signature Date