The Wellness Center

Welcome to the Office

Date _____ First Name_____ M.I. ____ Last Name _____

Address _____ City/State/ZIP _____

Home/Cell Phone# _____ Work Phone _____ Spouse's phone _____

Email _____ Driver's License # _____

Social Security # _____-____-_____ Birth Date _____ Age _____ Sex ____

Marital Status S M D W Spouse/Partner's Name _____

Children(s) Names and ages: _____

Employer _____ Occupation _____

Spouse's Employer _____ Spouse's Occupation _____

Emergency Contact & phone # _____ Relationship _____

How were you referred to our office? _____

Have you ever had Chiropractic care before? _____ If yes, when and where? _____

Please check reasons for consulting the office:

_____ I am interested in wellness and natural health care
_____ I am in pain and need help
_____ I am here for a free 15 minute initial consultation and am considering becoming a patient. I understand there is a charge for consultations after the initial 15 minutes.
_____ I had a personal injury or accident
_____ Other

INSURANCE INFORMATION

- Is this injury/illness work-related? _____ Have you reported it to your employer? _____
- Do you have any type of Health Insurance? Y/N Name of Insurance Company _____
  Guarantor's Name _____ Guarantor's Date of Birth _____

**** Please allow the front desk assistant to make a copy of your insurance card and driver's license for verification ****

FINANCIAL POLICY

Our policy requires payment in full for the first visit for all services rendered at the time of service to allow time to verify insurance coverage. There is a 10% time of service discount. As a courtesy we will file your health insurance but you understand and agree that regardless of third party liability (insurance of any kind) you are ultimately financially responsible for all charges incurred on your account. You further understand and agree that if your account is not paid within 90 days from the date of service (and other payment arrangements have not been made) the assistance of a collection agency will be enlisted and you will be responsible for any expenses incurred in collecting your account.
No call/no show appointments (if not cancelled 24 hours before) will be subjected to a $25 fee that will not be billed to the insurance. All return checks are subject to a $30 processing fee.

Method of payment: Cash _____ Check _____ Credit/Debit _____

By my signature I agree that all information given is complete and accurate to the best of my knowledge. I understand that all information given is completely confidential.

Patient Signature _____ Date _____

1040 N. Main Street
Huntingburg, IN 47542

Phone 812-683-2215
www.dcwellnesscare.com

The Wellness Center

PRIVACY PRACTICES – PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (3 pages in the back on clip board) for The Wellness Center and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

Signature _____ Printed Name _____Date_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:
a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.
Musculoskeletal care contributes to your overall well-being. ***The risk of injuries of complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:
a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care at The Wellness Center.

Signature _____ Printed Name _____Date_____