STEWART
WELLNESS & CHIROPRACTIC

Informed Consent for Chiropractic Treatment

Doctor Name:____

I hereby request consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative therapy) and any other associated procedures: physical examinations, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, massage, etc. on me by the doctor of chiropractic named above and/ or other assistants and/ or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments.

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 judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

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

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that 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 of Patient

____
Signature of Patient (or representative if minor)

__________________________ Date

1455 S. Semoran Blvd., Unit 177
Casselberry, FL 32707
(407) 960-1542 PH
(407) 960-1538 FX

New Patient Intake Form

Name____ Date_____________________
Address____ State___________ Zip______
Cell Phone _______________________ Email ________________ Date of Birth________ Age______
Referred by_________________________________ Social Security #________________________
Occupation_________________________________ Employer_____________________________
Marital Status S M D W Spouse Name__________________________
Number of Children/Ages_________________________ Spouses Occupation_____________________
Have you ever received Chiropractic Care? Yes No If Yes When____________________________

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system and spine, that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

Please circle for each of the following:		Patient Comment If answer is Yes	Chiropractor's Comments
Current Health Habits:		____________	____________
Did/do you smoke?	Y N	____________	____________
Did/do you drink alcohol?	Y N	____________	____________
Diet, do you eat healthy foods?	Y N	____________	____________
Have you been in accidents/trauma?	Y N	____________	____________
Have you had surgery and organs		____________	____________
removed/replaced?	Y N	____________	____________
Drugs, including Prescription?	Y N	____________	____________
Teeth problems?	Y N	____________	____________
Eye problems?	Y N	____________	____________
Hearing problems?	Y N	____________	____________
Exercise regularly?	Y N	____________	____________
Do you sleep well?	Y N	____________	____________
Did/do you have occupational stress?	Y N	____________	____________
Physical stress?	Y N	____________	____________
Emotional/Mental stress?	Y N	____________	____________
Hobbies/Sports injuries?	Y N	____________	____________
Sleeping posture? O side O stomach	O back	____________	____________

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present Complaint/Reason for Seeking Care in this Office:
Major____
Pain or Problem started on____
Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other________________
Does this pain shoot, radiate, or travel in your body? Where?______________________________
Are you experiencing numbness or tingling in any area of your body? Where?__________________
What activities aggravate your condition/pain?____

What activities lessen your condition/pain?____
Is this condition worse during certain times of the day?__________________________________
Is this condition interfering with work?__________ Sleep?__________Routine?_______Other?______________________
Is this condition progressively getting worse?____
Please Circle where your at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Other Doctors seen for this condition____
Any home remedies? ____

Please mark any of the following that you have now or have experienced:
Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

Have you been under drug and medical care?____
What Medications are you taking?____
How long?_________________ Have you had surgery?_________________ What?_________________ When?_________________
What side effects have you experienced from the drugs and surgery?_________________________
Females Only – Date last Menstrual Period began on________________________ Are you possibly Pregnant?___________
Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other__________________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

About Your Care
There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Reconstructive Care** 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 report of findings. Then you'll be able to begin a course of care that fits your goals.

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 do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.
Patient or Guardian Signature____Date_________________________

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(407) 960-1542

Date: ____________________

As a courtesy, we will assist you in filing your insurance forms. We will verify your insurance and we require that you pay any unmet deductible and co-payment on each visit. We will then bill you if any balance remains after the insurance company has paid. **The following information MUST BE COMPLETE, if not, we will require payment in full from you on each visit.**

Patient Name:____

Primary Members Name:____

Relationship to Primary Member:____

Social Security Number:____

Insurance Co. Name:____

Insurance Co. Address:____

Insurance Co. Phone Number:____

If Major Medical – Group/Policy Number:___________________________________

If Auto Accident/Workers Comp – Claim Number:____________________________

If Auto Accident/Workers Comp – Adjuster's Name:__________________________

If there is an attorney – Name:____

Address:____

PH Num.:____

Medicare Only

Medicare requires a $140.00 deductible to be met before paying at 80%. Once the deductible has been met, you will be responsible for the 20% of the adjustment and FULL PAYMENT FOR ALL OTHER SERVICES. MEDICARE DOES NOT COVER

EXAMS, X-RAYS, THERAPY, SUPPLIMENTS, OR SUPPLIES. Please note: Although Medicare does not pay for x-rays, they do require that you have an exam and x-rays on file in order to treat you.

EVERYONE PLEASE READ CAREFULLY AND SIGN:

My attorney and/or insurance carrier are hereby requested and authorized to pay directly to Stewart Wellness & Chiropractic. Any monies due on my account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Stewart Wellness & Chiropractic the difference, if any, between the total amount of my bill and the amount paid by the attorney and/or insurance carrier. It is further understood, that I agree to pay Stewart Wellness & Chiropractic the full amount of my charges, should by condition be such that it is not covered by my policy or, for any reason the insurance carrier refuses to pay my claim. My signature below indicates that I have read, understood, and agree to the above conditions, and verify that the information provided is correct.

If settlement is not received or my insurance doesn't pay, I agree to a finance charge of 18% per annum. Should legal action to collect become necessary, I hereby authorize Stewart Wellness & Chiropractic to conduct a credit/asset check and agree to absorb any collection costs and attorney fees.

Signature of person responsible for bill:_______________________________________

Date:___________________________

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PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

_____________________________ _____________________________
Print Patient Name Patient's Signature

____
Date