THE BACK DOCTOR

First Name:_____ **Last Name**:_____ **Nickname**:_____

Address:_____**City:**_____ **State:**_____ **Zip Code:**_____

Mobile: _____ **Home:** _____ **Email:** _____

Would you like to receive text message reminders: Yes No

Date of Birth: _____ **Age:** _____ **Gender:** M F **Marital Status:** S M W D

Spouse Name: _____ **Number of children:** _____

Employer Name: _____ **Occupation:** _____

Who should we thank for referring you to our office? _____

PURPOSE OF VISIT

Main reason for this visit- Chief complaint: _____

When did this condition begin? _____ **Did it begin:** Gradually Suddenly

Type of pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

Is this related to an auto accident or work related injury? Yes No **If yes, when** _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No **Describe:** _____

Does the pain radiate to your arms or legs? Yes No **Is the condition getting worse?** Yes No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does your complaint interfere with: ___ Work ___ Sleep ___ Hobbies ____ Daily Routine

Have you seen anyone else for this? Yes No If Yes, who: _____

What did they do?_____

Please list any other complaints:

1:_____ 3:_____

2: _____ 4:_____

Please list any health conditions not mentioned: _____

Please list any medication you are currently taking and their purpose:_____

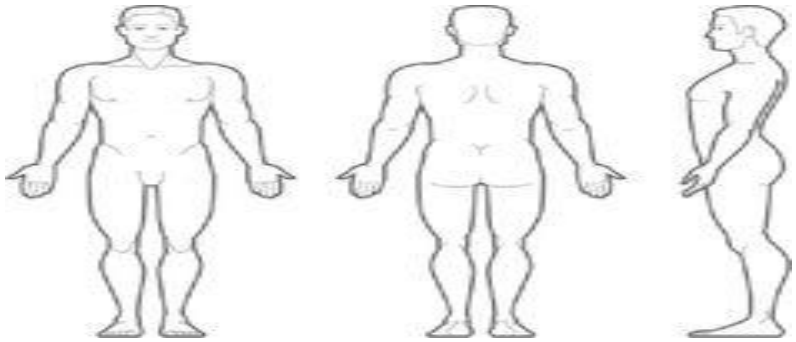
_____

Please list past surgeries and their year:_____

Please list any previous accidents and injuries: _____

_____

AREAS OF COMPLAINT – Place "X's" on the area (s) where you have pain and draw lines where it radiates:



Cervical Spine (Neck)

Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and can cause the following problems, do you have any of these?

___ Neck pain
___ Pain into your shoulders/arms/hands
___ Coldness in hands
___Headaches
___ Numbness/tingling in arms/hands
___ Thyroid condition
___ Dizziness
___ Hearing disturbances
___ Recurrent colds/flu
___ Sinusitis
___ Weakness in grip
___ Low energy/fatigue
___Allergies
___ Visual Disturbances
___ TMJ pain/clicking

Thoracic Spine (Upper and Mid Back)

Subluxations in your upper and mid back weaken the nerves that go to your lungs, heart, ribs/chest, and upper digestive tract, do you have any of these?

___ Heart palpitations
___ Heart attacks/angina
___ Recurrent lung infections
___ Heart murmurs
___ Asthma/wheezing
___ Pain on deep inspiration/expiration
___ Tachycardia
___ Shortness of breath
___ Hypoglycemia
___ Mid back pain
___ Reflux
___ Indigestion/heartburn
___ Rib/chest pain
___ Nausea
___ Ulcers/Gastritis

Lumbar Spine (Low Back)

Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet, do you have any of these?

___ Pain into your hips/legs/feet
___ Weakness in your hips/knees/ankles
___ Low back pain
___ Muscle Cramps in your legs/feet
___ Constipation/diarrhea
___ Numbness/tingling in your legs/feet
___ Coldness in your legs/feet
___ Frequent/difficulty urinating
___ Cramps in your legs/feet
___ Menstrual irregularities/cramping
___ Sexual dysfunction

Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who? _____ When? _____

Reason for visit? _____

What treatments were given?_____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No

Are you aware of any of your poor posture habits? Yes No Explain:_____

Payment and Cancellation Policy:

PATIENT INITIALS

Payment for Service

Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment. Payment for treatment can be rendered in the form of cash, check, credit card or health savings account.

- A 3.9% processing fee will be added to ANY card with a major credit card logo on it. We do not retain any portion of this fee.
- There are no additional fees for cash or check payments.
- The patient is responsible for any processing fees incurred for a declined/NSF check.

Medical Insurance

We do not accept any major medical insurance. Upon request we will provide you with an itemized receipt to submit to your insurance company or FSA/HSA if needed.

Compensation Claims

We do not participate with Compensation claims (worker's comp, auto accidents, etc.).

Cancellation Policy - PLEASE READ

Should you not be able to be present for your appointment; **12-Hour Advanced Notice WILL BE REQUIRED**, failure to do so WILL INCUR A FEE (see below):

***Failure to be present for your appointment **without proper notice** will incur FULL COST of **S**cheduled service.

*** Canceling or Re-scheduling your scheduled service within 12 hours will incur a $10 administrative fee. No Exceptions.

By my signature below, I acknowledge that I have completed this intake and agree to the policies above.

_____ _____ _____

Patient's Signature Name (Please Print) Date

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

PATIENT INITIALS

Chiropractic Care and Treatment. I will have the opportunity to discuss with the chiropractic doctor, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used including any necessary orthopedic, neurological, laboratory tests, imaging studies (X-rays, CT scans, MRIs, etc), including chiropractic adjustments, manipulation, mobilization and other therapies utilized by this office in the care of my condition. Furthermore, I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed.

Nature of Chiropractic Treatment. I understand that, on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feelings soreness or pain. During treatment, the doctor may use his or her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is often produced in some of the joint manipulation procedures and is caused by a separation of the smooth joint surfaces in much the same way a suction cup produces a popping sound when it is removed from glass or other smooth surface. Although a popping sound is not necessary, it is often a natural effect of joint movement.

Permission for Physical Contact. I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor contact me in some physically sensitive areas – such as during a procedure known as a "lumbar roll" where the doctor may contact with my rump (the posterior, superior spine of the Ilium) to adjust my sacroiliac joint, or some other similar or analogous procedure. I understand, however, that before any sensitive contact or procedure occurs the doctor will explain to me ① what is to be done, ② how it will be performed, ③ why it will be performed, ④ that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection. I also agree that if I ever have any questions, doubts or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinical staff member.

Risks of Chiropractic Care and Treatment. I understand and will be informed that there is risk of side effects and complications anytime a doctor is asked to intervene in a healthcare encounter with a patient the risk of serious complication from chiropractic treatment is rare and unlikely, nonetheless, rare events ranging from relatively minor muscle soreness, aches, sprains and strains, to injuries to the spinal discs, nerves and cord, or an occasional fracture or dislocation in compromised patients with certain concomitant diseases and illnesses have been reported in the scientific literature; that cerebrovascular accidents, such as a stroke, have also been reported; that these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in one-to-a-million to one-in-forty million cases of chiropractic, osteopathic, physical therapy and medical manipulation.

I do not expect the doctor to be able to anticipate all the potential risks or complications. Nor do I expect that the doctor to provide me assurances that I will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his or her best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

The most common and likely side effect of treatment will be muscular stiffness or soreness, described by some as akin to the ache people experience after exercising the first time in a long time; and that these effects are often transient and temporary.

Consent. By initialing each paragraph above in conjunction with the doctor, acknowledge that I have read and understood the above consent. By signing below I agree to submit to the above named chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from the office/practice indicated below.

_____ _____

Patient's signature (or Parent/Guardian) Date

HIPAA Notice of Privacy Practices:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. 1. Uses and Disclosures of Protected Health Information Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare

Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or

Neglect: Food & Drug Administration requirements: Legal proceedings: Law

Enforcement: Coroners, Funeral Directors and Organ Donation: Research:

Criminal Activity: Military Activity and National Security: Worker's

Compensation: Inmates: Required Uses and Disclosures of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required uses and Disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: Following is a statement of your rights with respect to your protected health information You have the right to request a restriction of your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy

notes: information complied in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state this specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14th 2003. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this -form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 804-728-2837.

By my signature below, I acknowledge that I have read and agree to the above HIPAA Notice of Privacy Practices .

_____ _____

Patient's signature (or Parent/Guardian) Date

THE BACK DOCTOR

Effective 1/1/2022

Cancellation Policy

To be respectful of the medical needs of our community as well as the provider's time, please be courteous and call promptly if you are unable to attend a scheduled appointment. This will allow us to re-allocate this time to someone who needs care.

If it is necessary to cancel/re-schedule your scheduled appointment,

we REQUIRE that you contact us 12 hours in advance.

How to Cancel Your Appointment

To cancel appointments please call (804) 728-2837 or text (804)944-4409. If you do not reach the receptionist, you may leave a detailed message on the voicemail including your full name along with the date and time of your appointment, please include the best phone to reach you at should there be any questions.

Late Cancellations and No Shows

- A late cancellation/re-schedule will result in a $10 administrative fee being billed to your account.
- Failure to be present to a scheduled appointment without any form of notification will incur a FULL-SERVICE FEE.

Please understand any Late Cancelations and No-shows inconvenience those individuals who need access to care as well as our staff.

- Late cancellations are any cancellation that occurs within 12 hours of your appointment.
- A "No Show" is someone who misses an appointment without making the effort to contact our office.

WE VALUE YOUR TIME; WE ASK THAT YOU DO THE SAME FOR OTHERS AS WELL