Informed Consent

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurances, auto accident insurance, worker's compensation insurance, parent/guardian, etc.) to allow Hewett Chiropractic to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor. Initial_____

Consent to Examination and Treatment: I give the doctors and staff of Hewett Chiropractic permission to perform all examinations, x-rays, and treatments deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor. Initial_____

Consent to Obtain Medical Records: I give the doctors and staff of Hewett chiropractic permission to obtain pertinent medical records if needed from other providers, offices, or hospitals which may assist with my care. Initial_____

HIPPA: Your health information is protected at Hewett Chiropractic. A copy of the full Health Information Policy for our office can be requested at the front desk. In brief, it states that we will not give out any information about you except as consented above. The only people we provide information to are your parent/guardian if you are a minor, or to whomever is responsible for your bill (i.e., insurance companies, third party, or attorney if you have one) Initial_____

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit in the electronic health record (EHR) and is available for my review. Currently, Hewett Chiropractic saves these reports electronically. I understand that, upon request, these reports are available to be printed or emailed to me for review. Initial_____

Pregnancy Waiver (Women Only): To the best of my knowledge, I am NOT pregnant nor is pregnancy suspected at this time. If you think you may be pregnant, please notify our staff. Initial_____

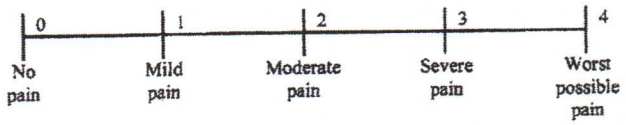
Patient or Guardian Signature: _____ Date: _____

Functional Rating Index

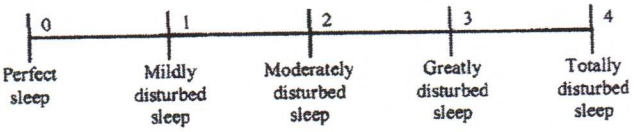
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

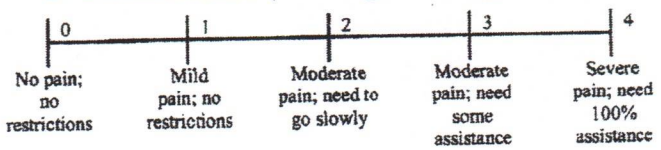
1. Pain Intensity



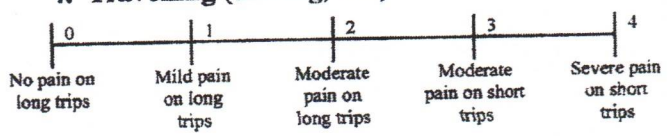
2. Sleeping



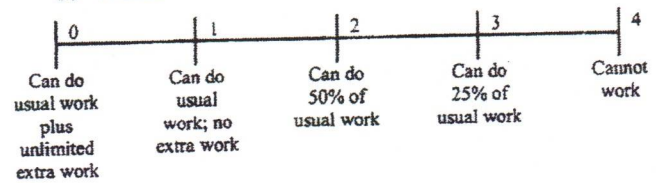
3. Personal Care (washing, dressing, etc.)



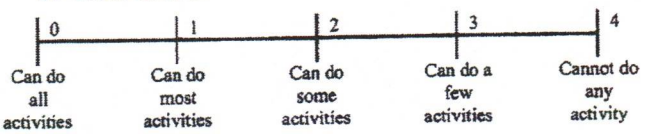
4. Travelling (driving, etc.)



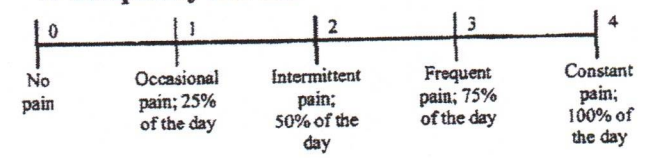
5. Work



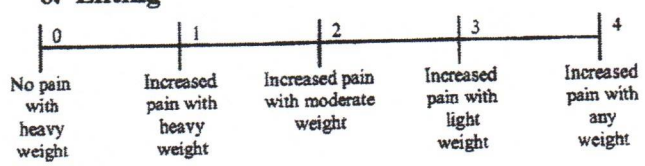
6. Recreation



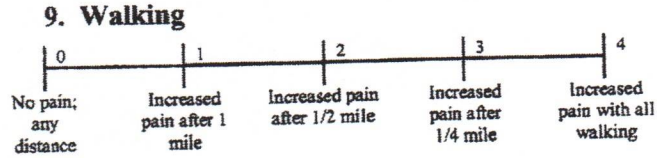
7. Frequency of Pain



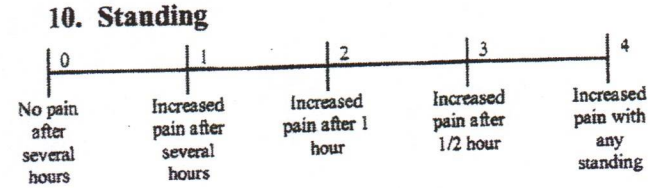
8. Lifting



9. Walking



10. Standing



_____

Patient's Signature

_____

Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name:** _____

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

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: _____ Age: _____

Preferred patient reminders: email / text Occupation: _____ Employer: _____

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

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language:** _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander Other / Decline to Answer

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home: _____ **Mobile:** _____

Relationship: Child / Parent / Spouse / Other: _____

Name of Previous Chiropractor: _____

Date of Last Chiropractic Adjustment: _____

Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION -- ***Please allow our staff to photocopy your insurance card.***

Insurance Self Pay (Cash) Personal Injury/Auto Other (please explain) _____

PRIMARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

_____

_____

_____

Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that bothers you the most today?

_____

Pain Level (circle one): 0 1 2 3 4 5 6 7 8 9 10

How did your pain begin? _____

Is your condition: Getting better or Getting worse

Is your condition: On and off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff/Sore

Radiating: Left/Right Base of Skull Shoulder Arm Hand Hip Leg Knee Foot Ribs

Other: _____

What makes it better? Ice Heat Rest Movement Stretching

What makes it worse? Sitting Standing Walking Lying down Sleep Overuse

Other: _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Auto, Fall, Work? _____

List of medications you are currently taking: _____

List of past surgeries: _____

Do you have any other physical complaints? _____

_____

Patient or Guardian Signature: _____