Dr. Jennifer L. Price, D.C.
New Patient Confidential Health History

Full Name: _____ Date: _____ Age: _____ Date of Birth: _____

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

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Driver's License: _____ Email:_____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ Zip: _____

Height: _____ Weight: _____ Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Partner

Name of Spouse/Partner: _____ Number of Children: _____

Name of Emergency Contact: _____ Contact Number: _____

What is the main purpose of this appointment (major complaint)? _____

_____

How long have you had this condition? _____ Date symptoms began or accident happened? _____

Is this injury due to an automobile accident? ☐ Yes ☐ No Did you injure yourself at work? ☐ Yes ☐ No

What aggravates your condition? _____

Is condition getting progressively worse? ☐ Yes ☐ No Have you lost any days from work? ☐ Yes (# of days lost: ___) ☐ No

Is this condition interfering with your... ☐ work? ☐ sleep? ☐ daily routine? ☐ other? _____

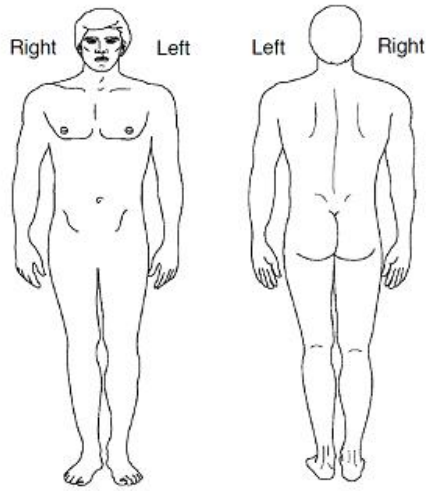
Have you ever had same or similar symptoms? ☐ Yes ☐ No If yes, please describe: _____

Have you seen anyone else for this condition? ☐ Yes ☐ No If yes, Who? _____ When? _____

What treatment did you receive? _____

What were the results of that treatment? _____

Use this diagram to indicate areas where you have your pain.



What is your pain right now?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

What is your typical or average pain?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its worst?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its best?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Describe any other concerns or complaints you would like to address with the chiropractor: _____

_____

Date of last physical exam? _____ Name of Physician: _____

List any surgeries (include dates): _____

List any serious illness(es): _____

Have you ever been under chiropractic care? ☐ Yes ☐ No When? _____ Where? _____

Have you been treated for any other health condition by a physician in the last year? ☐ No ☐ Yes If yes, please describe:

_____

List all medications/drugs you are taking (prescription as well as over-the-counter), and what condition/symptoms you take it for: _____

_____

List all supplements, vitamins, herbs, homeopathic remedies and/or botanicals which you take or use:

_____

_____

Health Habits - Please fill in using the following: H = Heavy use M = Moderate use L = Light use N = no use

Alcohol_____ Coffee_____ Tobacco_____ Drugs_____ Exercise_____ Sleep_____ Appetite_____

General Health History and Wellness Survey

Please indicate if you currently have, or have had in the past, any of the following conditions:

Condition:		Condition:		Condition:	
Allergy	☐Current ☐Past	Foot Trouble	☐Current ☐Past	Deafness	☐Current ☐Past
Dizziness	☐Current ☐Past	Stroke	☐Current ☐Past	Hepatitis (A B C)	☐Current ☐Past
Fatigue	☐Current ☐Past	Middle Back Pain	☐Current ☐Past	Neck Pain	☐Current ☐Past
Headaches	☐Current ☐Past	Thyroid Disease	☐Current ☐Past	Eye Pain	☐Current ☐Past
Loss of Sleep	☐Current ☐Past	Vascular Disease	☐Current ☐Past	Venereal Disease	☐Current ☐Past
Itching	☐Current ☐Past	Frequent Urination	☐Current ☐Past	Cancer	☐Current ☐Past
Varicose Veins	☐Current ☐Past	High Blood Pressure	☐Current ☐Past	Bed Wetting	☐Current ☐Past
Hemorrhoids	☐Current ☐Past	Anemia	☐Current ☐Past	Tumors/Cysts	☐Current ☐Past
Arthritis	☐Current ☐Past	Alcoholism	☐Current ☐Past	Diabetes	☐Current ☐Past
Nausea	☐Current ☐Past	Tuberculosis	☐Current ☐Past	Poor Posture	☐Current ☐Past
Asthma	☐Current ☐Past	Bruise Easily	☐Current ☐Past	Sciatica	☐Current ☐Past
Lower Back Pain	☐Current ☐Past	Nose Bleeds	☐Current ☐Past	Swollen Joints	☐Current ☐Past
Chest Pain	☐Current ☐Past	Nervousness	☐Current ☐Past	Colon Trouble	☐Current ☐Past
HIV/AIDS	☐Current ☐Past	Dementia	☐Current ☐Past	Depression	☐Current ☐Past
Prostate Trouble	☐Current ☐Past	Irregular Heartbeat	☐Current ☐Past	Heart Disease	☐Current ☐Past
Hot Flashes	☐Current ☐Past	Poor Circulation	☐Current ☐Past	Heavy Periods	☐Current ☐Past
Pleurisy	☐Current ☐Past	Tendonitis	☐Current ☐Past	Bursitis	☐Current ☐Past
Irregular Menstruation	☐Current ☐Past	Ear Noise (ringing/buzz)	☐Current ☐Past	Difficult Digestion	☐Current ☐Past
Difficult Breathing	☐Current ☐Past	SpinalCurvature/Scoliosis	☐Current ☐Past	Low Blood Pressure	☐Current ☐Past

I affirm that the details of my self-reported health history are complete and true to the best of my knowledge. I give my consent chiropractic consultation and physical examination.

Patient Signature: _____ Date: _____

Dr. Jennifer L. Price, D.C.
Patient Informed Consent to Chiropractic Care

Chiropractic is recognised as being an effective and safe form of healing for neuro-musculoskeletal conditions, and is the largest drug free health care profession in the world. Due to recent changes in the health and insurance industries, we want to inform you of possible risks associated with chiropractic care.Please be aware that you will be examined and tested before any adjustments or treatment is applied to ensure chiropractic care is appropriate for your case and condition.

Very rare risks may include muscle soreness, soft tissue bruising, muscle strains, ligament sprains, injury to a disc in the neck or low back, fracture, or possible aggravation of an underlying or pre-existing condition. Extremely rare is the risk of damage to neck blood vessels which can arise in stroke or similar symptoms.

Chiropractic adjustments of the spine are internationally recognised as being a reasonably safe and non-invasive alternative to traditional medical treatments for a variety of symptoms including: neck pain, low back pain, headaches/migraines, poor posture and more. Relief from annoying symptoms is just one of the many benefits of chiropractic care. The true purpose of the chiropractic treatment administered by your chiropractor is to detect and correct spinal misalignments (a.k.a. subluxations) and associated soft-tissue changes within the neuro-musculoskeletal system; with the intent of positively impacting the structure and function of the body as a whole. If you have any questions relating to the care you are about to receive, please speak to the chiropractor for clarification before signing.

By signing below, I acknowledge the above information and potential risks associated with chiropractic, and do not expect the chiropractor to be able to anticipate all potential risks and complications. Based on the information provided, I consent to the examination the chiropractor deems necessary, and to receiving chiropractic care, including spinal adjustments, as reported following my assessment.

_____	_____	_____/_____/_____
Patient Name – please print	**Patient Signature**	**Date**
_Jennifer L. Price, D.C._____	_____	
Chiropractor Name	**Chiropractor Signature**	

Privacy Practices - HIPAA Acknowledgement Form:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Today's Date:** _____

Dr. Jennifer L. Price, D.C.
Office Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy which we require you to read, agree to and sign prior to receiving any treatment. Please note:

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE**
- **We accept CASH, CHECKS, and CREDIT/DEBIT CARDS:**
    - **VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS**

Cash Policy

We request that all treatment be paid for at the time of service. If you are unable to pay your balance in full, we request that all accounts be cleared within thirty days. We do not offer extended payment plans. We do not send monthly statements.

We charge interest on any unpaid balances in the amount of 1.5% per month, equal to 18% per year on all balances after 30 days.

Insurance Policy

Health and Accident policies are a contract between you and your insurance company, and our office is not included in that contract. It is important that you understand that you are ***personally responsible*** for all services rendered to you in our office. Many insurance companies cover chiropractic treatment, but the amount which insurance will cover varies from policy to policy. Due to the variance in coverage amounts, we urge you to carefully review your coverage.

In general, Dr. Price does not contract with any insurance companies and she is considered to be an "Out of Network" provider. As a courtesy, ***our office will provide you with a superbill upon request, which you may submit to your insurer for any reimbursement to which you are entitled***. We ask that you pay 100% of your fees for treatment at this office, at the time of service. The only exception is the Windsor office location where Dr. Price is an "In Network" provider for many health plans. At the Windsor office, we will bill your insurance on your behalf for services rendered at the Windsor office, and you will be responsible for all co-payment and/or deductible payments at the time of service.

In the event that we bill your health insurance or personal injury auto insurance on your behalf, you agree to grant this office assignment of benefits and direct your insurance company to pay us directly. All checks received from your insurance company will be promptly credited to your account. You also grant this office power of attorney to endorse checks made out to you to be credited to your account.

Personal Injury/Worker's Compensation Insurance

Our office will bill Med-Pay insurance on your behalf and wait for payment from the insurance company. However, we ***will not wait for payment on Third Party Claims and our office does not accept Liens from Attorneys***. We will assist you in preparing the necessary paperwork to collect from the third party but we require payment in full at the time of service. The charge for narrative reports and record review is $75.00 per page.

Our office does not accept worker's compensation insurance of any kind.

Medicare

We are ***not preferred providers for Medicare and we do not accept assignment***. Medicare will only cover spinal adjustments for acute conditions, and no other services. Any other service will be your responsibility and you will not receive reimbursement from Medicare. We collect full payment for all charges at the time of service. ***We will bill Medicare for you and Medicare will reimburse you directly*** for 80% of any allowable charges that they deem medically necessary. We do not bill secondary insurances, but Medicare will forward any covered charges to your secondary insurance plan.

By signing below, I acknowledge that I have read and understand the terms of the financial policy above, and that I agree to these terms.

Signature _____ Date _____

Print Name _____