HIPPA Release

I understand that some of my health information may be used and/or disclosed to the doctor of Evans Family Chiropractic to carry out treatment, payment, or health care operations, and that a complete description of such uses and disclosures has been made available to me in writing. I also understand that I can request a copy of this privacy notice entitled "Our Privacy Policies", and that disclosures of my health information for any other reason must be agreed upon by me in writing. **Initial:_____**

Health Insurance/Payment Information

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Erik R. Evans and this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. **Initial:_____**

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. Chiropractors commonly use their hands or a mechanical device or the use of tables in order to restore mobility and function of joints that are not moving or functioning optimally. For many patients certain therapies or exercises may also be used to maximize healing and pain relief.

Possible Risks: The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or other treatment, if he/she is aware that such care may cause problems. It is the patient's responsibility to inform the doctor of any known pathological defects, illnesses, or deformities which would not otherwise come to the attention of the doctor. The most common adverse effects are minor and temporary and include stiffness or soreness after the first few days of treatment (similar to starting a new exercise regimen or having braces put on your teeth). Other rare but potential complications include muscular strain, fractures of bone, injury to interverteberal discs, nerves or spinal cord, or stroke/cerebrovascular injury *(estimated to be less that 1 in 2 million to 5.8 million cervical manipulations).* Complications from therapies used in addition to your adjustment are rare but may cause skin irritation, burns, soreness, bruising, or other minor complications.

Risks of remaining untreated: Delay of treatment often results in further deterioration of the condition and may lead to chronic pain and disability, or surgery.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. **Initial:_____**

Patient Printed Name:_____

Patient Signature:_____Date:_____

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other _____

Have you ever recieved chiropractic care in the past? Yes No When? _____ Results? _____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood T est _____

Spinal Exam _____ Chest X-Ray _____ Urine T est _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Circle P = Previously C = Currently

AIDS/HIV	P	C	Emphysema	P	C	Miscarriage	P	C	Scarlet Fever	P	C
Alcoholism	P	C	Epilepsy	P	C	Mononucleosis	P	C	Stroke	P	C
Allergy Shots	P	C	Fractures	P	C	Multiple Sclerosis	P	C	Suicide Attempt	P	C
Anemia	P	C	Glaucoma	P	C	Mumps	P	C	Thyroid Problems	P	C
Anorexia	P	C	Goiter	P	C	Osteoporosis	P	C	Tonsilitis	P	C
Appendicitis	P	C	Gonorrhea	P	C	Pacemaker	P	C	Tuberculosis	P	C
Arthritis	P	C	Gout	P	C	Parkinson's Disease	P	C	Tumors, Growths	P	C
Asthma	P	C	Heart Disease	P	C	Pinched Nerve	P	C	Typhoid Fever	P	C
Bleeding Disorders	P	C	Hepatitis	P	C	Pneumonia	P	C	Ulcers	P	C
Breast Lump	P	C	Hernia	P	C	Polio	P	C	Vaginal Infections	P	C
Bronchitis	P	C	Herniated Disk	P	C	Prostate Problem	P	C	Venereal Disease	P	C
Bulimia	P	C	Herpes	P	C	Prosthesis	P	C	Whooping Cough	P	C
Cancer	P	C	High Cholesterol	P	C	Psychiatric Care	P	C	Other _____		
Cataracts	P	C	Kidney Disease	P	C	Rheumatoid Arthritis	P	C			
Chemical Dependency	P	C	Liver Disease	P	C	Rheumatic Fever	P	C			
Chicken Pox	P	C	Measles	P	C						
Diabetes	P	C	Migraine Headaches	P	C						

Exercise

None
Moderate
Daily
Heavy

Work Activity

Sitting
Standing
Light Labor
Heavy Labor

Habits

Smoking -- Packs/Day _____
Alcohol -- Drinks/Week _____
Coffee/Caffeine Drinks -- Cups/Day _____
High Stress Level -- Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had — Description — Date

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

MEDICATIONS — ALLERGIES — VITAMINS/HERBS/MINERALS

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signed: _____ Date: _____

EVANS FAMILY CHIROPRACTIC

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Referred By _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co
& Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co
& Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. **Erik R. Evans D.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext ____

Best time and place to call _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Home _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident: Auto Work Home Other

To whom was accident reported?
Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: Sharp Dull Throbs Numb Aches Shooting Burns
Tingles Cramps Stiffness Swelling Other

How often do you have this pain? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark picture with an X where symptoms occur