SARATOGA CHIROPRACTIC

NEW PATIENT – DEMOGRAPHIC AND INSURANCE INFORMATION (PLEASE PRINT)

Today's date: _____

Patient Information: (As listed on your insurance card, if applicable)

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Parent or Legal Guardian Name: _____

Parent/Guardian Primary Phone Number (Cell / Home / Work): _____

Parent/Guardian Secondary Phone Number (Cell / Home / Work): _____

Parent/Guardian Email Address:_____

Referring Physician: _____ Phone: _____

If you would like your health insurance billed for services card must be present

How did you hear about Dr. Purcell?

____ Internet Search

____ Health Insurance Company

____ Word of Mouth (Who may we thank for sending you in? _____)

____ Doctor/Healthcare provider, Name: _____

____ Other, please explain: _____

Height: _____ Weight: _____ Blood Pressure: _____

Are you currently taking prescription medication? ____ Yes ____No

If "Yes", please list medication and related condition/reason prescribed below:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

SARATOGA CHIROPRACTIC

376 Broadway Suite L4

Saratoga Springs, NY 12866

Phone: 518-886-8189

Statement of Acknowledgement of Financial Responsibility by Parent or Gaurdian

I understand that I am financially responsible for charges incurred at this office including copayments, deductibles and charges not covered by my insurance.

I realize my care may be subject to prior authorization from the insurance carrier and I accept responsibility for charges which may not be approved. The insurance company will review all documentation submitted by Dr. Purcell for review of medical necessity and base their decision upon this documentation.

I understand this office agrees to notify me if a service is not covered and will notify my if my care is not approved by the insurance company as soon as possible. If a treatment plan is approved this office will make me aware of the number of visits allowed over the time frame given. Initial visits can be denied and this may be beyond the office's ability to notify me prior to rendering acute care while waiting for insurance approval. These charges will my responsibility if denied by the insurance company.

I further understand this office will seek payment from me for any services rendered that my health plan determines to be not medically necessary.

If I receive multiple bills that are not paid in a timely manner, I understand additional fees will be charged and will end up going to collections.

If I suspend or terminate my care in this office, any fees for professional services rendered to me will be automatically due and payable.

I agree to pay all out of pocket payments or copayment at the time of the office visit.

Cancellation policy: Any missed appointments or appointments not cancelled with at least 24 hours notice are subject to a $25 cancellation fee.

I have read and understand what has been stated above.

Minor's name (printed): _____

Parent/Gaurdian name (printed): _____

Parent/Gaurdian Signature: _____ Date: _____

Saratoga Total Wellness Chiropractic, PLLC
376 Broadway Suite L4 Saratoga Springs, NY 12866

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____Saratoga Total Wellness Chiropractic PLLC_____.

I understand that the Notice describes the uses and disclosures of my protected health information by _____Saratoga Total Wellness Chiropractic PLLC_____ and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____
Employee Name *Today's Date*

INFORMED CONSENT TO EXAMINE AND TREAT A MINOR

The word "*chiropractic*" is derived from the Greek words "*chiro*", meaning "*hand*" and "*praxis*", meaning "*practice*"; so chiropractic is literally healthcare performed by hand. As a patient at Saratoga Total Wellness Chiropractic, PLLC, you should expect your child to be touched, moved, assisted, and adjusted by the doctor. Occasionally, complications may arise from the care we render. ***The purpose of this consent form is to inform you of the possibility of complications or adverse effects.*** Please read, initial, and sign the following consents to examination and treatment, permitting us to continue.

CONSENT TO EXAMINATION

Our chiropractic examination procedures include, but are not limited to, your child's health history, posture and range of motion evaluation, orthopedic and neurological testing, palpation of various body structures, spinal and extremity mobilization, manual or mechanical muscle testing and palpation, and referral for specialized testing such as blood evaluations, diagnostic imaging, and other tests.

> *On very rare occasions, physical symptoms may manifest or complications may arise during this examination.* ***By initialing here,*** _____, *I authorize the doctor to examine my child to assess his/her health concern(s). This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.*

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CONSENT TO TREATMENT

Chiropractic therapeutic procedures include, but are not limited to, spinal and extremity manipulation/mobilization, manual or mechanical muscle therapy, exercise demonstration and prescription, physiotherapy applications such as ice, heat, ultrasound, and electrotherapy, referrals to other practitioners, nutritional recommendations, and advice on posture and homebased self-care.

The most common adverse effects of chiropractic treatment are short-term soreness and/or a temporary increase in pain. **The likelihood of initial soreness or increased pain has been found to be similar to that of starting an exercise program[1].** In fact, a systematic review of the literature indicated **that most adverse events that could be attributed to spinal manipulation were benign and transitory[2].**

Fractures are rare and usually the result of an underlying bone pathology that we will try to assess during your history and examination. An event sometimes attributed to chiropractic manipulation is a stroke resulting from a cervical artery dissection[3]. This event is very rare, occurring at a frequency of between one per million and one per five million visits to a chiropractic office. To date, no study has

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1 Bronfort et al., 2001; Hurwitz, Moregenstern, Vassilaki, & Chiang, 2005
2 Gouvela, Castanho, & Ferreira, 2009
3 Rothwell, Bondy, & Williams, 2001; Smith et al., 2003

shown a causal relationship between cervical spine manipulation and stroke. Research has demonstrated that **a patient is as likely to have seen a primary care medical doctor as a doctor of chiropractic prior to experiencing a cervical arterial dissection[4].** In other words, the association of strokes and visits to either chiropractors or primary care physicians was equal, suggesting that the cause of the strokes could not be associated with any element unique to chiropractic care.

Naturally, we will discuss our treatment plan with you. We will also inform you of other options for care, to the best of our knowledge. Please note that all forms of healthcare include some form of risk. In fact, there are even risks to not receiving care that may include a worsening of your current complaint or development of other untoward complications.

Please read the above before signing this consent. If you have further questions or desire more information, simply ask and we will provide it.

Upon signing this form, I hereby request and authorize Dr. Jaclyn Purcell, and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to my dependent minor child. I also understand that there is no guarantee or warranty for a specific cure or result. I consent to examination and treatment of my child.

As of today's date, I have the legal right to select and authorize health care service for the minor child named below.

Child's Name (printed):_____

Your relationship to child:_____

Legibly printed Parent/Guardian name:_____

Signature:_____ Date: _____

CUSTODY SITUATIONS

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent/Guardian Signature:_____

4 Cassidy, et al., 2008