# Chiropractic Registration & History

Name______________________________ Social Security #______________

Address________________________________________________

City______________________ State__________ ____________ Zip__________

Home Telephone ( )______________ Age______ Birthdate__________ Marital Status: M S W D

Work Telephone ( )______________ # Children______ Spouse's Name______________

Occupation______________________ Whom may we thank for referring you?______________

## HEALTH INFORMATION

Have you had previous chiropractic care? ☐ Yes ☐ No Date ______________

Main Complaint________________________________________________

________________________________________________

Other Complaints________________________________________________

How long have you had this condition?______________________________

Have you had similar conditions in the past?______________________________

Does this condition affect your work? ☐ Yes ☐ No

Does this condition affect your family or social life? ☐ Yes ☐ No

What aggravates this condition?______________________________

________________________________________________

Other Doctors seen for this condition______________________________

________________________________________________

Are you taking any medication? ☐ Yes ☐ No If yes, please list:______________

________________________________________________

What helps your symptoms?______________________________

Have you had; Surgery? ☐ Yes ☐ No Falls? ☐ Yes ☐ No Accidents? ☐ Yes ☐ No

When? ______________ Please describe______________________________

________________________________________________

Date of last physical examination______________

Please check ☑ conditions or symptoms you currently have or have had in the past:

- Abdominal Pain ☐
- Anemia ☐
- Arm or Shoulder Pain ☐
- Back Pain ☐
- Bladder Problems ☐
- Chest Pain ☐
- Circulatory Problems ☐
- Constipation ☐
- Depression ☐
- Diabetes ☐
- Digestive Disorder ☐
- Dizziness ☐
- Fatigue ☐
- Headaches ☐
- Heart Problems ☐
- High or Low Blood Pressure ☐
- Hip or Leg Pain ☐
- Hot Flashes ☐
- Insomnia ☐
- Kidney Problems ☐
- Loose Stool ☐
- Lung or Bronchial Disorder ☐
- Memory Problems ☐
- Menstrual Problems ☐
- Neck Pain ☐
- Nervousness ☐
- Numbness ☐
- Palpitations ☐
- Prostate Disorder ☐
- Sinus Problems ☐
- Swollen Joints ☐

## INSURANCE INFORMATION

Is this condition due to:

A work related injury? ☐ Yes ☐ No An automobile accident? ☐ Yes ☐ No

If you answer yes to either of the above questions, please complete other side of form.

Medicare# (If applicable) ______________________________

Do you have Health Insurance? ☐ Yes ☐ No

Company______________________________

Address______________________________

Policyholder______________ Employer______________

Group#______________ ID#______________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Chiropractor and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature______________________________ Date______________

Guardian or Spouse's Signature ______________________________

# RNR CHIROPRACTIC
**58 Hancock St, Braintree, Ma. 02184**
**Phone:781-848-7200 Fax:781-848-7222**
**Rnrchiropractic.com**


## Privacy Policy

## THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at RNR CHIROPRACTIC we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO or PPO or your employer, if they are or may be responsible for the payment of services provided to you.

Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your recent care Or other health related information that may be of interest to you.

You have the right to request restrictions on or use of your protected health information for treatment, payment and operation purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information with out your authorization in these following circumstances:

If we provide health care services to you in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

If we are ordered by courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the Federal Privacy rules.

Initial__________ Date__________

**RNR CHIROPRACTIC**
**58 Hancock St. Braintree, Ma. 02184**
**Phone:781-848-7200 Fax:781-848-7222**
**Rnrchiropractic.com**

# HEALTH CARE AUTHORIZATION FORM

Patient's Name:______________________________
Patient's SS#________________________________ D.O.B.________________

The patient identified above authorizes RNR CHIROPRACTIC to use and or disclose protected health information in accordance with the following specific authorization:

I give open room authorization to RNR CHIROPRACTIC to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for these conversations.

# RNR CHIROPRACTIC

58 Hancock St. Braintree, Ma. 02184
Phone:781-848-7200 Fax:781-848-7222
rnrchiropractic.com

## DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

### CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and medicine. Chiropractic seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its' inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

### ANALYSIS

A doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such VSC &/or VSS are detected, chiropractic adjustment and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its' inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the recuperative powers of the body.

### DIAGNOSIS

Although doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC and VSS, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions is he/she has any concern as to the nature of his/her condition. Your doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. 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 health care, if he/she is aware that such care might be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to attention of the doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

### RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the VSC and VSS. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the results are phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, conditions that do not respond to Chiropractic care may come under the control or be helped trough medical science co-treatment. The fact is the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

PATIENTSIGNATURE______________________________ DATE_________________________

# RNR CHIROPRACTIC

**58 Hancock St. Braintree, Ma. 02184**
**PHONE: 781-848-7200 Fax: 781-848-7222**
**rnrchiropractic.com**

**Consent to Chiropractic Care**

I,_____________________, date of birth_________________authorize the performance upon myself of the following procedure(s);

Examination and/or treatment

I realize that these procedures are to be performed by or under the direction of the Chiropractic Physician, Dr. Daniel Rogers.

Physicians, Chiropractors, Osteopaths & Physiotherapists using manual manipulation are required to advise their patients that with neck problems there have been rare incidents of injury to the vertebral artery during the course of care. These have caused strokes or stroke-like occurrences, which are usually temporary in nature. The chances of this happening are approximately 1 in 3-6 million adjustments. In addition, with neck or back problems there have been rare incidents of rib separation or fracture, bruising, swelling or aggravation of symptoms. APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOUR RISKS.

I hereby consent to the Chiropractic care as indicated and explained to me. If during the course of care unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and care as may be indicated by sound and prudent chiropractic practice, which may require additional x-rays, Chiropractic, Orthopedic, neurological, and/or laboratory testing or consulting with another doctor.

No guarantee or warranty has been made to regarding my results.

I have read and understand the above statements and hereby give my consent to Chiropractic care.

Print name:_____________________Signature____________________Date____________

Guardian's name:________________Signature____________________Date____________

Witness:_______________________Signature____________________Date____________

# RNR CHIROPRACTIC

**58 Hancock St. Braintree, Ma. 02184**
**phone: 781-848-7200 Fax: 781-848-7222**
**rnrchiropractic.com**

**Appointment Policy**

If you are unable to make an appointment for any reason, we require that you reschedule as soon as possible. This office reserves the right to charge a $25 no show fee for missed appointments unless a 24 hour notice has been given.

**Financial Policy**

All services rendered in the office are the responsibility of the patient. If you have insurance, which includes Chiropractic as a benefit, this office will extend a courtesy of processing insurance forms and mailing statements as necessary. If your policy has a limit or dollar amount cap, it is up to the patient to keep track of your insurance. We do not guarantee that your insurance company will pay for the usual and customary fees of this office. Nor will we enter into a dispute with your insurance company over reimbursement.

Patients are expected to make timely payments and follow up with your insurance carriers as appropriate. Accounts are considered delinquent when they are 90 days old.

All payments are expected at the time of your visit. Under special circumstances payments may be postponed, but all balances must be paid in full by the end of the week. Patients may not exceed a $100 co-insurance balance.

If your deductible has not been met, you are expected to pay for services rendered until your deductible has been satisfied.

If you do not have insurance that covers Chiropractic care we will be happy to arrange a Cash Plan for you. If you discontinue care for any reason other than discharge by the Doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.

I certify that I have read and understand the above policies and agree to comply with said policies.

_______________________________ _______________
signature Date