Lowe Chiropractic Health Questionnaire

Name_____ **Home Phone**_____

Address_____ **Cell Phone**_____

City_____ **State**_____ **Zip code**_____ **Date of Birth**__/__ **Male/Female**

Age_____ **SS#**_____ **Email**_____

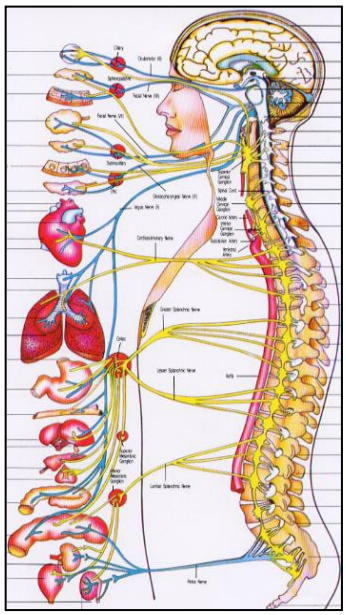
Occupation_____ **Marital Status: M W D S Spouse Name**_____

No# of Children_____ **Name of Children**_____

Insured's Name (if other than self)_____ **Birth date** _____

1. **Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?**
   _____
2. **Science tells us your spine like your teeth need to be cared for regularly.**
   How often do you get adjusted by a chiropractor? Frequently/only when you hurt/1 x monthly/never
3. **When was your last complete spinal examination including x-rays?**_____ **☐ Never**
4. **Do you know if you have a spinal curvature ☐ spinal arthritis ☐ or inherited spinal problem ☐**
5. **Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back as well as, loss of Nerve Health. Do you hear these sounds when you move your head or neck? ☐ Yes ☐ No**
6. **If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No**
7. **Poor posture leads to poor health and early death. How would you rate your posture?**
   Poor 1 2 3 4 5 6 7 8 9 10 Excellent
8. **Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level over the last 3 months.**
   None 1 2 3 4 5 6 7 8 9 10 Intense
9. **Please circle or list any health symptoms or health complaints you are experiencing.**

Neck pain L/R	Leg pain L/R	Heart Disease	Thyroid
Mid-back pain	Asthma	Cancer	Allergies:_____
Low-back pain	Headaches/Migraines	Constipation	_____
Arm pain/Numbness L/R	Diabetes I/II	Menstrual pain	_____



10. **Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (use back if necessary)**
    1._____ **2.**_____ **3.**_____
11. **Please list any surgeries you have had.** _____
12. **Do You Smoke? ☐ Yes ☐ No**
13. **Spinal health is vitally important to ensure you and your baby are healthy. Is there a chance you are pregnant? ☐ Yes ☐ No**
14. **Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.**
    When was your most recent injury at home?_____ **Car accident?**_____ **Slip or fall?**_____
15. **Improper sleeping positions can cause spinal misalignment and spinal damage. What sleeping position do you sleep in:**
    ■ Back ☐ Stomach ☐ R Side ☐ L Side
16. **Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often**
17. **Are you ? ☐ Right Handed ☐ Left Handed**
18. **Please list vitamins/supplements you take:**_____
19. **If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely?**
    ■ Yes ☐ No

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian):_____ **Date:**_____

Lowe Chiropractic Clinic- Chiropractic Works!
59 E. Green St. (515) 462-5807

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian of_____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Signature **Date**

Lowe Chiropractic Clinic

59 E. Green St., Winterset, IA 50273, (515) 462-5807

Lowe Chiropractic Clinic

Patient Name:_____File:_____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Borio Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Joseph Borio.

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Borio to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Lowe Chiropractic Clinic

Notice of Privacy Practices

This notice describes how health information about you is stored, may be used, and or disclosed.

How We Store Your Information: Patient information is stored here in the office on a secure server with no outside access. X-Rays images are also stored on the server and the hard copies of your file and X-Rays are stored here in our office. All storage is secure and meets or exceeds HIPPA requirements and regulations.

What We Do Not Do With Your Information: Information about your financial situation, medical conditions, and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our patients to anyone who receives our services. Know that any and all patient information is considered confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care, billing to an insurance company or to provide you with health or services which may require communication between Borio Chiropractic Health Center and health care providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and insurance.

No Patients information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will ever be used without patient's express written advance permission.

Print Patient Name _____

Signature_____ Date _____

Lowe Chiropractic Clinic- Chiropractic Works!
59 E. Green St., Winterset, IA (515) 462-5807

Lowe Chiropractic Clinic
Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our staff for more information.
- If you are eligible & choose a payment plan that allows for "prompt payment" discounts.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of 04/15/2019 our office will be unable to extend any type of discounts other than those listed above.

☐ I want to receive eligible discounts

☐ I do not want to receive eligible discounts

Patient Signature:_____ Date:_____