Baxter Village Health Center

New Patient Information

(To be completed by all new patients receiving Chiropractic, K-Laser, Massage Therapy)

Name: _____ DOB: ____/____/_____
First Middle Initial Last MM DD YYYY

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: Male/Female Social Security #: _____-_____-_____

Marital Status: Single Married Divorced Widow Other: _____

Home #: (_____)_____-_____ Cell #:(_____)_____-_____

Work #:(_____)_____-_____ Email Address: _____

May we contact you via email? Y/N

Emergency Contact: _____ Relationship: _____

Phone: (_____)_____-_____

Referral Information

(How did you hear about us OR who referred you to us?)

Friend/Family : _____ Internet Search

Physician : _____ Social Media

May we contact them to say "thank you" for referring you? Y or N Word of Mouth

Insurance Information

(Not all services rendered are covered by insurance)

Policy holder: _____ DOB: ____/____/_____

Insurance Company: _____ Phone: (_____)_____-_____

Subscriber ID #: _____ Group #: _____

Name of Insured: _____ DOB: ____/____/_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibilities for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I also acknowledge it is my responsibility to obtain all referrals my insurance may require (ie. many insurance companies require a referral from a physician to continue seeing a physical therapist 30 days after the initial visit).

Patients's Signature: _____ Date: ____/____/_____

(Parent or Guardian if patient is a minor)

Baxter Village Health Center

Insurance Assignment

Must be signed by all who wish to go through insurance now or in the future.

I, _____, request, authorize and further direct that any insurance company which is liable for reimbursement for services rendered make payments directly to you, I request payment of government or medical benefits to the undersigned physician's office below. I further authorize and give my permission for you to endorse checks, drafts and payments received in my behalf for medical services rendered. It is further understood that if any point the monies received exceed my indebtedness, these funds will be returned to me by your office and it is my responsibility to comply with any subrogation clause which may be contained in my medical insurance.

I herby assign and transfer to you any cause of action that exists in my favor against such company and authorize you to prosecute said actions, either in my name or your name, as you see fit. It is agreed, however that in transferring this cause of action it is agreed between all parties that your interest in this case shall be limited to the amount of medical bills rendered to me by you and your appointee. It is further understood and agreed by all parties that the transfer of this cause shall be limited to medical bills rendered on my behalf and that are related only to the case in question. For the above named purpose, I further authorize and transfer to you my limited power of attorney so that you may act in my behalf in this regard, and this regard only. It is agreed that you will make all reasonable efforts to collect sums due from the insurance carriers with a liability in this case; however, it is my ultimate responsibility to pay in full for all services rendered to me.

I herby state and agree to this authorization and assignment may not be withdrawn unilaterally.

Patient Name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian if patient is a minor)

Witness Signature: _____

Cancellation Policy

(To be completed by all new patients receiving Chiropractic, K-Laser, Massage Therapy)

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.
Office appointments which are cancelled with less than 24 hours notification may be subject to cancellation fee of 50% of the full cost of the originally schedule service, (ie a 60 minute massage is $75 therefore cancellation fee would be $37.50).

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management and provider approval.

Patient Name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian if patient is a minor)

Witness Signature: _____

Baxter Village Health Center

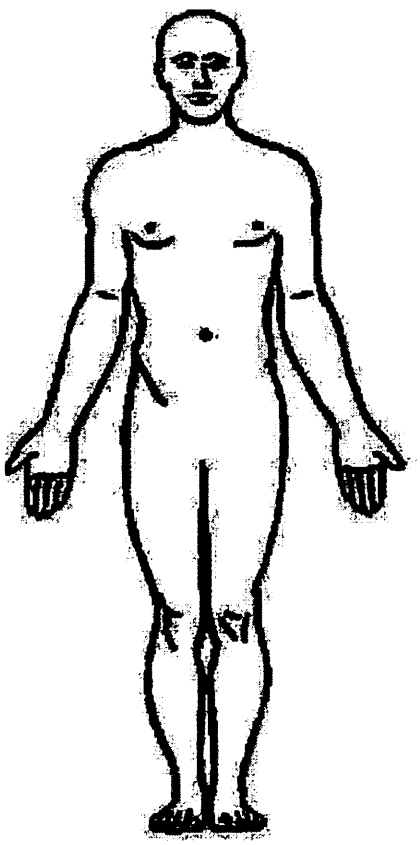
Diagram Of Concern

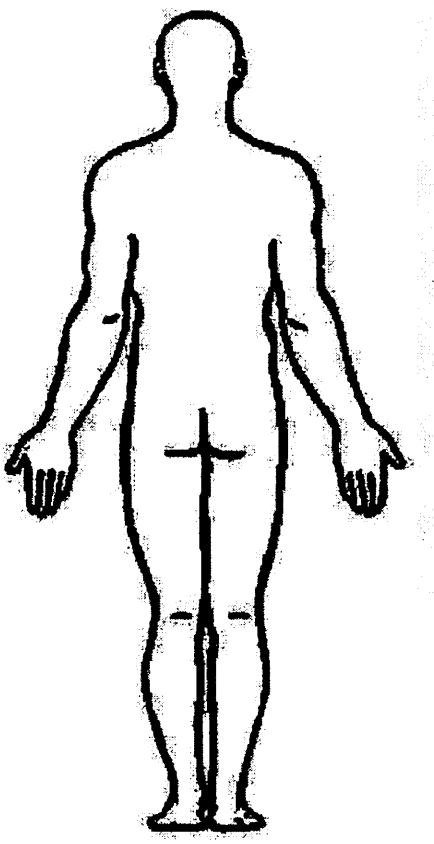
Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

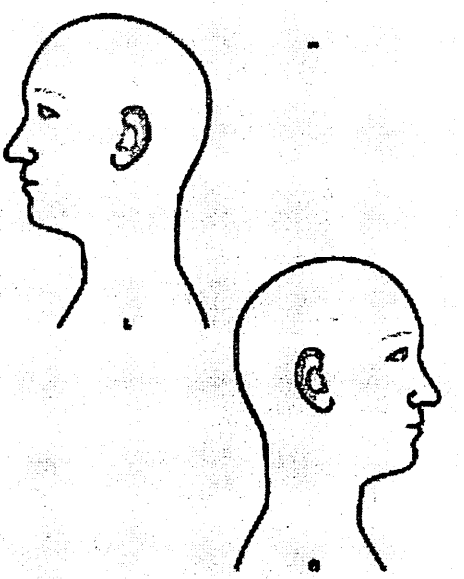
A= Ache O= Other

B= Burning P= Pins & Needles

N= Numbness S= Stabbing







1171 Market Street Suite #112 Fort Mill, SC 29708

Baxter Village Health Center

Chief Complaint-Chiropractic Care

Have you seen a chiropractor before? No Yes

Date of last physical exam: _____/_____/_____

Reason for consulting this office (please check all that apply)

O Pain O Optimal Health O Auto Accident O Pregnancy

O Sports Injury Date of Injury: _____ O Auto Injury Date of Injury: _____ O Personal Injury Date of Injury: _____ O Other: _____

Date symptoms appeared: _____/_____/_____

Describe your symptoms: _____

Describe the pain:

O Deep O Superficial O Dull O Sharp O Burning O Other

O Achy O Throbbing O Stabbing O Shooting O Boring

List of other health care provider(s) you have seen for this injury/complaint.

_____

What was their diagnosis? _____

Have you had x-rays/MRI/CT on area: No Yes If yes, explain: _____

What percent of the day do you have pain? __ 0-25% __ 26-50% __ 51-75% __ 76-100%

When do you feel your best? __ morning __ afternoon __ evening

When do you feel your worst? __ morning __ afternoon __ evening

Have you had injuries in the past? *Include all auto accidents, falls, sports trauma, etc and dates:*

_____

Have you ever broken any bones? No Yes If yes, describe and give date: _____

I have provided correct and complete information the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.

Patient's/Guardian's Signature: _____ Date: _____

Baxter Village Health Center

Medical/Health History

(To be completed by all new patients receiving Chiropractic, K- Laser and Massage Therapy)

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems may affect your overall course of care. Please circle if you are currently experiencing or have a history of the following:

Alcoholism	Allergies	Anemia	Arteriosclerosis	Dental Concerns
Arthritis	Asthma	Back Pain	Paralysis	Autoimmune Disease(s)
Bronchitis	Bruise Easily	Cancer	Chest Pain/Condition	Hearing Difficulties
Cold Extremities	Constipation	Cramps	Depression	Bladder Difficulties
Diabetes	Digestive Problems	Dizziness	Ear Ringing	TMJ/TMD
Emphysema	Epilepsy	Gout	Heart Disease	Sexual Dysfunction
Excessive Menstruation	Eye Pain/Difficulties	Fatigue	Frequent Urination	Infertility Concerns
Headaches	Hemorrhoids	High Blood Pressure	Hot Flashes	Whooping Cough
Hepatitis A, B, or C	Hypoglycemia	Injuries	Intestinal Parasites	Chicken Pox
Irregular Heart Beat	Irregular Cycle	Kidney Infection	Kidney Stones	Poor/Excessive Appetite
Loss of Memory	Loss of Balance	Loss of Smell	Loss of Taste	Anxiety
Low Blood Pressure	Appendicitis	Bleeding Disorder	Emotional Difficulties	Dry Mouth
Multiple Sclerosis	Mumps	Pacemaker	Weight Loss/Gain	Women:
Neck Pain/Stiffness	Nervousness	Nosebleeds	Poor/Excessive Thirst	Date of last menses?
Polio	Poor Posture	Prostate Difficulties	Sciatica	Are you pregnant?
Scarlet Fever	Surgery	Ulcer	Vision Problems	If so, due date:
Shortness of breath	Sinus Infection	Sleep Issues or Insomnia	Spinal Curvature	# of Pregnancies:
Stroke	Swelling of Ankles	Swollen Joints	Thyroid Condition	____ births ____ miscarriages
Tuberculosis	Ulcers	Varicose Veins	Venereal Disease	Type and date of delivery(ies):

Other: _____

If you answered yes to any of the above please explain: _____

_____

Have you ever been hospitalized? _____ If so, please list the reason: _____

Caffeine _____X per day OR week
Tobacco _____X per day OR week
Drugs _____X per day OR week
Water _____X per day OR week
Artificial Sweeteners _____X per day OR week

Refined Sugar _____X per day OR week
Alcohol _____X per day OR week
Soft Drinks _____X per day OR week
Exercise _____ X per day OR week

List of current medications and/or supplements (include dosage if known): _____

_____

I have provided correct and complete information to the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.

Patient's/Guardian's Signature: _____ Date: _____

BAXTER VILLAGE HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

We understand that medical information about you and your health is personal and we are committed to protecting this information. When you receive chiropractic treatment from us, a record of the treatment you receive is made. Typically, this record contains your treatment plan, your history and physical, any x-ray and test results that you provide to us, and billing record. This record serves as a:

- Basis for planning your treatment.
- Means of communication between Baxter Village Health Center doctors, staff and your other health care providers, if any, that you wish us to share them with.
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information.

OUR RESPONSIBILITIES
We are required by law to:

- Maintain the privacy and security of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice; and
- Notify you if we are unable to agree to a requested restriction.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1. **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your chiropractic treatment at this clinic or any other clinic where you seek treatment. For example, we may share your information with your primary care physician or other specialists upon request.
2. **For Payment.** We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party

3. **For Contacting You.** We may use your address, phone number, e-mail and clinical records to contact you with notifications, text messages, birthday and holiday related messages, billing inquiries, information about treatment alternatives, or other health related information. If contacting you by phone, we may leave a message on your answering machine or voicemail.
4. **Appointment Reminders.** We may use and disclose medical information to remind you of an appointment, if applicable.
5. **As Required by Law.** We will disclose medical information about you when required to do so by federal or state laws or regulations.
6. **Lawsuits and Disputes**. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
7. **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order or subpoena.

List **ANY** other parties who can have access to your information: *(includes treatment, billing, appointments, etc.)*

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand and agree to the HIPPA Patient Privacy Notice that was presented to me. I also acknowledge that a copy will be made available if I request one.

_____

(Patient Printed Name)

_____ ____/_____/_____

(Patient or Legal Guardian Signature) (Date)

_____ ____/_____/_____

(Witness / Employee Signature) (Date)

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE