GILCHER CHIROPRACTIC

FOR OFFICE USE ONLY

Patient Number: _____

Patient Information

Date: _____

Name: _____ Gender: ❒ Female ❒ Male Social Security Number: _____-_____-_____

Date of Birth: _____ Age: _____ Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Number: _____ Home Number: _____ Work Number: _____

How did you hear about our office? ❒ Internet ❒ Facebook ❒ Family/Friend: _____ ❒ Another Provider ❒ Other: _____

Email: _____

Primary Doctor: _____ PCP Office Phone Number: _____

Job Occupation: _____ Employer/Company Name: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Children's Names & Ages: _____

Insurance Information

Name of Primary Insurance Company: _____ Relationship to Insured: ❒Self ❒Spouse ❒Child ❒Other: _____

Name of Primary Insured: _____ Primary Insured's Date of Birth: _____

Identification Number: _____ Group Number: _____

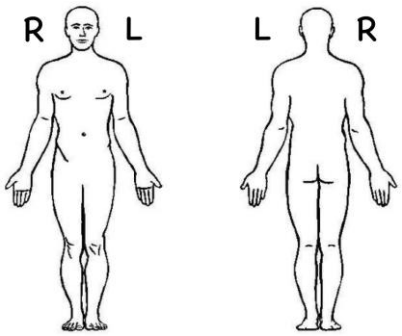
Do you have a secondary insurance? ❒Yes ❒No

Complaint/Discomfort Information

List your major complaints in Order of Severity, include date the complaint began and the type of pain (sharp, dull, burning, etc.)

1. _____
2. _____
3. _____
4. _____

Circle or put an "X" in the areas of pain and/or discomfort on the image below



Medical History
Do you have any of the following health conditions and/or symptoms?

❒Asthma ❒Arthritis ❒Cancer ❒Diabetes ❒High Blood Pressure ❒Low Blood Pressure ❒Lower Back Pain ❒Mid-Back Pain

❒Neck Pain ❒Pain Down Leg ❒Shoulder Pain ❒Hip Pain ❒Loss of Balance ❒Shooting Headaches ❒Frequent Headaches

❒Migraine Headaches ❒Abdominal Pain ❒Swollen Ankles ❒Painful Menstruation ❒Irregular Menstruation ❒Knee Pain

❒Upper Back Pain ❒Pain in Hands ❒Numbness in Legs ❒Irritability/Moodiness ❒Pain in Joints ❒Swollen Joints ❒Dizziness / Vertigo

❒ Throat Trouble ❒ Sinus Trouble ❒ Slipped Disc ❒ Chronic Fatigue ❒ Digestive Troubles ❒ Sleeping Difficulties

Have you seen a Chiropractor before? ❒Yes ❒No If you answered yes, Where? _____

When were you seen? _____ Caused By: ❒Work Related ❒Auto Accident ❒Personal Injury ❒Other: _____

Smoking Status (Check One): ❒Everyday Smoker ❒Occasional Smoker ❒Former Smoker ❒Never Smoked

The Centers for Medicaid and Medicare Services (CMS) require providers to report both race and ethnicity of their patients:

Race: ❒American Indian or Alaska Native ❒Asian ❒Black or African American ❒White (Caucasian) ❒Native Hawaiian or Pacific Islander
❒Other: _____ ❒I Decline to Answer

Ethnicity: ❒Hispanic or Latino ❒Not Hispanic or Latino ❒I Decline to Answer

Have you had any surgeries, accidents, or major injuries we should be aware of? ❒Yes ❒No
If yes, please list any surgeries, accidents, or major injuries below along with the date the incident occurred

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Below, list all medications, vitamins, herbs, and/or minerals you currently are taking along with the dosage of each.

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____

Below, list all medications you are allergic to along with the onset date and the reaction you have to these medications.

1. _____ Onset Date: _____ Reaction: _____
2. _____ Onset Date: _____ Reaction: _____

Weight: _____ Height: _____'_____ Blood Pressure: _____/_____

Preferred Language: ❒English ❒Spanish ❒Other: _____

Clinical Summary

I choose to decline receipt of my clinical summary after each visit.

Patient Signature: _____ Date: _____

Terms of Acceptance for Gilcher Chiropractic

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being. Not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature: _____ Date: _____

Pregnancy Release
(Section for FEMALES only)

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.

Patient's Signature: _____ Date: _____

If you are pregnant, when is your expected date of delivery? _____

Medical Insurance and File Authorization

I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment below. I authorize payment of any medical benefits directly to Charles M. Gilcher D.C. of Gilcher Chiropractic for any services rendered to me. I am aware any charges not covered by my insurance are my responsibility. I have read and fully understand the above statements.

Patient Signature: _____ Date: _____

Patient Consent to the Use and Disclosure of Health Care Information For Treatment, Payment, or HealthCare Operations

I, _____ understand that as part of my health care, Gilcher Chiropractic originates and
Print Name

maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for the future care or treatment. I understand that this information services as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine operations such as assessing quality and reviewing the competence of healthcare professionals

I understand a copy of the Notice of Information Practices that provides a more complete description of information uses and disclosures is available upon request, accessible on Gilcher-chiro.com website or in a binder located in the front office. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information maybe used tor disclosed to carry out treatment, payment, or health care operations

I understand and give permission to Gilcher Chiropractic to use my name, address, phone number, and clinical records to contact me with my appointments, birthday cards, contest awards, holiday related cards, post cards, and information about treatment alternatives or health related information via mail, fax, phone, or email.

I understand and give permission to Gilcher Chiropractic to post my picture, testimonial, and/or name to promote chiropractic in any way, shape, or form. Including Gilcher-chiro's website, Facebook, and the open waiting room boards.

I understand that Gilcher Chiropractic is not required to agree to the restrictions request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Gilcher Chiropractic reserves the right to change their Notice of Information Practice at any time without notice. Should Gilcher Chiropractic change their Notice of Information the updated version will be available upon request, accessible on Gilcher-chiro.com, or in a binder located in the front office.

The use or disclosure requested under this authorization will/will not result in direct or indirect remuneration to Gilcher Chiropractic from a third-party.

Patient's Name: _____ Date of Birth: _____

Signature of Patient or Representative: _____ Date: _____

Description of Representative's Authority to Act for the Patient: _____

Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic X-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the fact then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all the other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinion if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to have the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name: _____

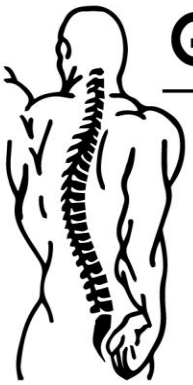
Patient's Signature: _____

Name Printed of Parent/Legal Guardian/Parental: _____

Relationship to Patient: _____

Parent/Legal Guardian's Signature: _____

Date: _____



GILCHER CHIROPRACTIC

Charles M. Gilcher, D.C.

3030 Fort Street
Lincoln Park, MI 48146

313.928.2777
fax 313.928.2825

AUTHORIZATION FOR RELEASE

Date: _____

Patient's Name: _____

Date of Birth: _____

Request To: _____

Attention: _____

Requesting: _____

I hereby authorize the requested entity above, my physician, or insurance company to disclose to Dr. Charles M. Gilcher any and all necessary information which they may have acquired by examination or other means of my physical or mental condition, and I hereby release them of any consequences thereof.

Patient's Signature: _____ Date: _____