Patient Data **Date** _____

First Name: _____**Middle Initial:** ____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (____)_____**Work Phone:** (____)_____

Cell Phone: (____)_____**Date of Birth:** _____

Email: _____

Sex: □Male □Female **Marital Status:** □Single □Married □Other

Employment Status: □Employed □Full Time Student □Part Time Student □Other (check one)

Spouse Data

Is your spouse a patient in the clinic? □Yes □No

First Name: _____**Middle Initial:** _____ **Last Name:** _____

Home Phone: (____)_____**Work Phone:** (____)_____

Employer Data

Name: _____

Address _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Name:_____ **Phone:** (____)_____

Relationship to you: _____

Did someone refer you to our office? If so whom?_____

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Cedar Valley Chiropractic

Dr. Jennifer Rasmussen
Dr. Nicholas Dugger

Financial Policy

Here at Cedar Valley Chiropractic we are committed to providing you and your family outstanding Chiropractic Care and Healing Services. If you have insurance that will contribute to your Chiropractic care, we will file your insurance claims for you as a courtesy, however, please keep in mind that your agreement is between you and your insurance company and Co-pays and payment of services will be expected at the time services are rendered unless you have made arrangements in advance.

Payment Method (Please circle one)

Cash/Check/Credit Card Health Insurance Car Insurance / Liability Insurance

Students

If you are a student, are your parents paying for your bill? Yes / No

If yes, Name of Parent(s): _____

Address: _____ City_____ State: _____ Zip Code_____

Signature on File

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize direct payment to my doctor.

I permit a copy of this authorization to be used in place of the original.

Signature: _____Date:_____

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Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Cedar Valley Chiropractic Sport & Spine respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, email or text. Cedar Valley Chiropractic Sport & Spine will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

☐ I do not consent to any email or texting communication.

☐ I consent to receiving communications via email and text including, but not limited to: communication about my medical condition, advice from my healthcare providers, the scheduling of appointments and/or other communications that do not reveal my protected health information.

E-mail address you are consenting to communicate through:_____

Phone number you are consenting to communicate through:_____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature:_____ Date_____

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PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The most frequent treatment I use as a Doctor of Chiropractic is spinal (and extremity) manipulative therapy. I may use my hands, the table or a small mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much like the noise heard when you crack your knuckles. You may feel a sense of movement. You may not always hear the pop or feel the movement.

Other treatments

Additional treatments may include: stretching, soft tissue techniques that are similar to massage, modalities such as ice, heat, electrical muscle stimulation, traction, and exercise.

Analysis/Examination/Treatment

As a part of your visit you are consenting to the following procedures as the Dr. deems necessary. Check any procedures that you may have questions about.

____spinal manipulative therapy	____palpation	____vital signs
____range of motion testing	____orthopedic testing	____neurological testing
____muscle strength testing	____postural analysis	____radiology testing
____electrical muscle stimulation	____traction	____hot/cold
____rehabilitative exercise	____soft tissue therapy –manual or instrument assisted	
____other		

The material risks in the chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and rib strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during your examinations to screen for contraindications to care such as previous stroke or osteoporosis; however, if you have a condition or develop a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Dr. Jennifer Rasmussen
Dr. Nicholas Dugger

Probability of risks occurring

Fractures are rare occurrences and generally result from some unknown underlying weakness of the bone. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. The most common side effect is stiffness or soreness following treatment much like soreness after a deep tissue massage.

Availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics, and rest
- Medical care, physical therapy, Rx drugs such as NSAIDS, muscle relaxers, and pain-killers
- Possible surgical intervention (in some cases)

Risks and dangers of remaining untreated or not following through with the Dr.'s recommendations

Remaining untreated may allow the formation of adhesions and scar tissue and reduced mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer treatment is postponed. Not performing your home care plan such as ice, rehabilitation exercise, or activity modifications that the Dr. prescribes can lead to recurring episodes of symptoms that may lead to worsening of the condition and/or chronicity.

DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions with Dr. Rasmussen, Dr. Dugger, or their staff and have had my questions answered to my satisfaction. By signing below I state that I understand any risks, have weighed the risks involved and have decided that it is in my best interest to undergo the treatment recommended. Having been informed I voluntarily give my consent to the treatment.

Name: _____ Dr. Jennifer Rasmussen / Dr. Nicholas Dugger

Signature: _____ Signature: _____

Date: _____ Date: _____

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Dr. Nicholas Dugger

Have you ever been diagnosed with/currently have any of the following conditions/symptoms?

Unexplained weight gain	Y	N
Difficulty sleeping or unusual loss of energy	Y	N
Unexplained fever or chills	Y	N
Sleep apnea or excessive snoring	Y	N
Cancer or tumor	Y	N
Allergies	Y	N
Immune system deficiency/disorder	Y	N
Sudden loss or blurring of vision	Y	N
Any condition of the eyes	Y	N
Dizziness, vertigo, or ringing in the ears	Y	N
Recurrent ear infections or other ear trouble	Y	N
Chronic or recurrent sore throat or difficulty swallowing	Y	N
Chronic or recurrent sinus problems	Y	N
Heart attack, congestive heart failure, or unexplained chest pain	Y	N
Aneurysm, arterial, or vascular disease/condition	Y	N
Poor circulation or swelling of the feet and legs	Y	N
High cholesterol	Y	N
Blood clots	Y	N
Any heart or vascular condition	Y	N
Asthma or shortness of breath	Y	N
Emphysema or obstructive lung disorder	Y	N
Chronic cough or bronchitis	Y	N
Chronic or current constipation or diarrhea	Y	N
Liver or gallbladder condition	Y	N

Name_____ Date_____

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Colitis, diverticulitis, or Celiac disease	Y	N
Ulcers, heartburn, indigestion, or acid reflux	Y	N
Unexplained nausea or vomiting	Y	N
Stomach pain or intestinal disorder	Y	N
Kidney stones or other kidney conditions	Y	N
Urination problems, including increased frequency,	Y	N
Difficulty with initiation, or blood in the urine	Y	N
Recurrent bladder or urinary tract infections	Y	N
Loss of or concern about sexual function	Y	N
Unexplained rashes or unusual spots/moles	Y	N
Eczema, psoriasis, or other skin conditions	Y	N
Migraine or severe headaches	Y	N
Seizures, tremors, or uncontrolled movements	Y	N
Stroke, mini-stroke, or TIA	Y	N
Concussion or head injury	Y	N
Numbness or tingling	Y	N
Unusual or unexplained weakness in arms or legs	Y	N
Difficulty with balance or walking, not due to pain	Y	N
Thyroid condition	Y	N
Diabetes	Y	N
Menopause or menstrual problems	Y	N
Depression or anxiety	Y	N
Unusual or high stress	Y	N
Unexplained mood changes	Y	N

Name_____ Date_____

Dr. Jennifer Rasmussen
Dr. Nicholas Dugger

Back or neck pain	Y	N
Pain in arm, leg, hand, or foot	Y	N
Previous injury to a joint that required treatment	Y	N
Broken or dislocated bone	Y	N
Joint replaced or surgical procedure performed on joint	Y	N
Bursitis or tendonitis	Y	N
Arthritis	Y	N
Fibromyalgia	Y	N
Any other condition of the muscles, bones, or joints	Y	N

Have any of your immediate family (parents, grandparents, siblings, or children) had any of the following? Please circle. Heart attack or heart disease High blood pressure Diabetes Osteoporosis Cancer Stroke or blood clot Thyroid condition Back problems Arthritis

Have you had any surgeries? Please list: _____

Do you take any prescription medications? Please list: _____

_____

Do you take any over-the-counter medications or supplements? Please list: _____

_____

Have you taken any prescription steroids (cortisone, prednisone, inhaler, or oral)? N Y

Do you use tobacco products currently? N Y In the past? N Y

Do you exercise regularly? N Y

Name _____ Date _____

Dr. Jennifer Rasmussen
Dr. Nicholas Dugger

NOTICE OF PRIVACY PRACTICES SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Cedar Valley Chiropractic uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Cedar Valley Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Cedar Valley Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Cedar Valley Chiropractic may disclose your information for public health activities, health and safety, and/or governmental functions in order to comply with workers compensation laws and other regulations. You have a right to request restriction of your health records, report, and retain a copy of your health records, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer, Dr. Jennifer Rasmussen, Dr. Nicholas Dugger, and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Cedar Valley Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

This Summary of the Notice of Privacy Practices is first in effect on this date of April 14, 2003.

If you have any questions or complaints, please contact Dr. Jennifer Rasmussen or Dr. Nicholas Dugger at (319) 268-9009.

_____ _____

Patient Signature Date

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Cedar Valley Chiropractic

Dr. Jennifer Rasmussen
Dr. Nicholas Dugger