Araya Chiropractic Wellness Center

Thank you for coming!

Date:

Name:

Address, Town, ZIP:

Best Phone:

Email Address: (please print) ______________________________

Why are you here today? ______________________________

Did you used to go to the Chiropractor? Yes No

Are you nervous or already comfortable with adjustments? (circle one or both!)

Is your reason for coming a). a "new thing?" Or b.) a "had for a while thing?"

If you had to guess - are you going to need a.) 1 or 2 visits over a few days? b.) 8 or 10 visits over a few weeks? c.) I have no idea!

Are you concerned that care may be expensive? Yes No

Have you heard of chiropractic maintenance or wellness care? Yes No Not Sure

A chiropractor is a (circle one or more)

a; bone doctor b: back doctor c: muscle doctor

d: a quack e: spine and nerve system doctor

f: a wellness practitioner that finds subluxations or misalignments of the spine and uses adjustments to allow the body to heal itself without drugs and surgery.

Anything else you want Dr. Rick to know? ______________________________

Do you want us to bill your insurance? No Yes Date of Birth Please ______________

Medicare Patients ONLY: Social Security Number Please _____-_____-______

Do you think insurance will cover your visit completely? Yes No

Do you have a deductible? Have you met it? Yes- Amount? _______ /No/Who knows? N/A

Do you have a specialist co-pay? Yes- Amount ____ / No/ Who knows? N/A

Would you like to use your HSA Card? Yes/ N/A

Office Use:

__self ___Anthem ___medicare___cigna ___ Conncare___ other ____________

___NP ___A__A1__TE codes 1.______2.______3.____4.____ Ref…___Jeffer _____MD PT ER

HIPPA PRIVACY AGREEMENT

THE PATIENT IDENTIFIED AUTHORIZES Araya Family Chiropractic, LLC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

I give permission Araya Family Chiropractic, LLC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information. If Araya Family Chiropractic, LLC contacts me by phone, email, or whatever electronic means I share with them, , I give them permission to leave a message. I give Araya Family Chiropractic, LLC permission 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 care. Should I need to speak with doctor at any time in private, the doctor will provide a room or a time by phone for these conversations. By signing this form I hereby authorized Araya Family Chiropractic, LLC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I agree that all the in-formation provided to Araya Family Chiropractic, LLC is true to the best of my recollection.

RIGHT TO REVOKE AUTHORIZATION You have the right to revoke this HIPPA AUTHORIZATION, in writing, at any time. However, your written request to revoke this HIPPA AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Araya Family Chiropractic, LLC. The written notice must contain the following information: Your name, Social Security number and date of birth; A clear statement of your intent to revoke this HIPPA AUTHORIZATION; The date of your request; and Your signature. The revocation is not effective until it is received by the Privacy Official. This HIPPA AUTHORIZATION is requested by Araya Family Chiropractic, LLC for its own use/disclosure of PHI. You have the right to refuse to sign this HIPPA AUTHORIZATION. If you refuse to sign this HIPPA AUTHORIZATION section, Araya Family Chiropractic, LLC will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures and any supportive care on me (or on the patient named below, for whom I am legally responsible) by Araya Family Chiropractic, LLC.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some reported risks, including, but not limited to, fractures, disc injuries, dislocations and sprains. There are reports of stroke as well. This is controversial in and out of the chiropractic profession, at this time. While these risks should not be considered normal, usual or common occurrences they have been reported to have occurred in the practice of chiropractic. I do not expect the doctor to be able to anticipate and explain all 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 facts then known, is in my best interests.

I further understand that there may be other treatment options available for me. Other modes of treatment may have their own reported risks and I should talk to other practitioners about them if I choose to participate in those treatments. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of any symptoms and care options. I have been encouraged to participate in chiropractic care if I would like to do so.

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 the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TERMS OF ACCEPTANCE

Chiropractic is a healing art that adjusts the spine and corrects subluxations or misalignments that may have an detrimental effect on health and wellbeing. The State of CT defines it like this: *The practice of chiropractic means the practice of that branch of the healing arts consisting of the science of adjustment of the human body in which vertebral subluxations(misalignments) and other malpositioned structures that may interfere with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells of the body, which may be a cause of disease, are adjusted.* (see CT General Statues Chp. 372.)

Chiropractors use their hands and adjusting instruments to adjust the vertebra into position. Chiropractors locate the subluxations using movement of the vertebra, visual indicators, posture, gait, chiropractic instrumentation, imaging or other various means. In a chiropractic practice, it is also common for health advice or commentary to include topics that would help build health and correct subluxations. These discussions might include diet and nutrition, exercise and movement advice, supplementation, orthotics, ergonomics, and anything pertaining to healthy living.

Chiropractors do not compete with physical therapists, medical professionals, massage therapists or even other chiropractors. Please allow other professional to give their opinions and practice their healing arts without comparison to a completely different healing profession. As you might expect, a chiropractor is likely to have a chiropractic approach different than one found in any other office. By coming to Araya Family Chiropractic, LLC you are accepting chiropractic care in this office on this basis. **You may always see another practitioner while under chiropractic care.** Other professionals personal opinion about chiropractic does not validate or invalidate your care here. We are happy to help you decide if you wish to participate in chiropractic as practiced in this office.

Family Members included:

______________ ______________ ______________

______________ ______________ ______________

Signature: ______________________ **Date:** ______________