Name: _____

Date: _____

As a new patient in our office we want your experience to be the best it can be.

Please let us know if you have any questions.

REGULAR FEES:

New Patient Examination……$150

Re-examination……$100 (has not been seen in the office for 6+ months).

Adjustment……$65

Soft Tissue work (Graston Technique®, and Therapeutic Exercises) ……$65

PHASES OF CHIROPRACTIC CARE:

Initial intensive care:	Adjustments 2-3 times per week until symptom free.
Corrective healing:	Adjustments 1 time per week without re-lapse of symptoms.
Wellness:	Regular adjustment based on individual patient needs.

PAYMENT OPTIONS:

☐ Insurance **Deductibles May Apply.**

With your approval and signature below, **Duxbury Wellness Center** will bill your insurance and payment will be made directly to our office.

Co-payment: _____ Max visits/dollar amount per year: _____
60./visit regular visit once insurance coverage exhausted.

☐ Patient Payment

If you do not have health insurance, we are happy to let you know about our special Care Savings Plans, which will make it affordable for you to receive Chiropractic care.

Providing the highest level of patient care is our priority.
Visits are scheduled so there is limited or no wait time.

A "No Show" fee of $60 will be charged for any scheduled appointment if a patient does not arrive and does not give prior notice of cancelation or reschedule.

Signature: _____ **Date:** _____

Name: _____

Date: _____

Last Name:			Marital status:	
First Name:	Middle:		Single / Mar / Div / Sep / Widow	
Email:	**Birth Date:**		**Age:**	**Sex:**
Address:	**City:**		**State:**	
ZIP Code:	**Cell:**		**Home:**	
Occupation:	**Employer:**			

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

City:	Sate:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /	

Have you had surgery ☐ Yes ☐ No If Yes, list date and reason for surgery:

Present Illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other: **Medications:**

Family History of Illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Signature: _____ **Date:** _____

Name: _____

Date: _____

Please explain why are you here?

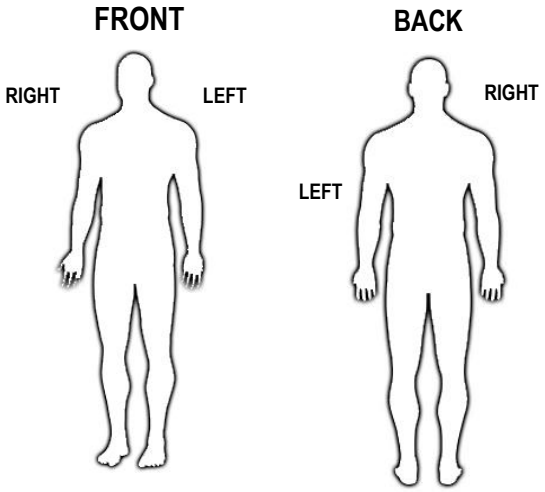
When did this issue/injury begin? / /
Have you ever had similar concerns in the past? ❑No ❑ Yes, If Yes, When? / /
Have you ever seen a Chiropractor before? ❑No ❑ Yes, If Yes, When? / / Doctor:

Use diagrams to indicate pain or numbness.

Draw an **X** for location of **pain**

Circle O areas of **numbness** and/or **tingling**

Use → to show if **pain travels** from one area to another



Rate your current level of pain with an X:

(0 = No Pain and 10 = Unbearable pain)

|---|---|---|---|---|---|---|---|---|---|---|

0 5 10

✓ **all that apply.**

Symptoms are: ❑Constant ❑Intermittent

My pain is: ❑Dull ❑Sharp ❑Aching ❑Burning ❑Shooting ❑Tight/Stiff ❑Other_____

I experience: ❑Tingling ❑Numbness ❑Nausea ❑Anxiety ❑Depression ❑Fatigue

Symptoms/Concerns: Please ✓ all that you have experienced in past 6 months.

☐ Chest pain	☐ Loss of taste	☐ Pins/needles in hands	☐ Headache
☐ Back pain	☐ Blurry vision	☐ Pins/needles in feet	☐ Rib pain
☐ Ear ringing	☐ Head feels 'heavy'	☐ Pins/needles in arms	☐ Dizzy
☐ Loss of taste	☐ Arm/shoulder pain	☐ Pins/needles in legs	☐ Fainting
☐ Nervousness	☐ Cold hands/feet	☐ Pain while sitting	☐ Neck pain
☐ Constipation	☐ Shortness of breath	☐ Pain while standing	☐ Tension

How did you hear about us? _____

Signature: _____ **Date:** _____

Name: _____

Date: _____

HIPPA AGREEMENT

This notice describes how Chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

In the course of your care as a patient at Duxbury Wellness Center, we may use or disclose personal health related information about you only when necessary. Your protected health information, including your clinical records, may be used by our staff or disclosed to another party such as:

- another healthcare provider if it is necessary to refer you for further diagnosis, assessment or treatment.
- an insurance carrier or employer if they are responsible for the payment of services provided to you.
- your name, address, phone number may be used to contact you regarding appointment reminders or other health information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide healthcare services to you in an emergency.
- If we are required to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at any time. You have the right to inspect and/or copy your health information for as long as the information remains in our files. Additionally, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

Signature: _____ Date: _____

CONSENT TO TREAT

I have received information about my condition and proposed treatment program as well as alternative courses of care, the benefits, risks and side effects of the treatment and consequences of not having the proposed treatment. I understand and am informed that, as in all health care, in the practice of Chiropractic and massage there are some rare risks to treatment, including but not limited to, muscle strains, sprains, fractures, dislocations, disc injuries and strokes.

Signature: _____ Date: _____