HEPPE
CHIROPRACTIC

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PERSONAL INFORMATION

PLEASE PRINT

First Name:__________________ **MI:**__ **Last Name:**_________________ **Preferred Name:**________

Address:__________________________ **City:**______________________ **State:**_____ **Zip:**_______

Birthdate:__/_____/_____ **Gender:**_________ Are you open to photos being used of your treatments on social media? Y N

SSN:__________________ **Referred by:**______________________ Tag for Social Media:________________

Primary Phone:____________________ **Cell:**_______________________**Work:**________________

Email:_________________________________ **Alternate email:**______________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided

Emergency Contact: (Name, Relationship, Phone):____

Signature of Patient, Parent or Legal Guardian (if minor):___________________________________

Do you have any children? (Names, ages):____

Do you have any pets? (types, names):____

REASON FOR VISIT

What is the reason for today's visit? ☐ Neck Pain ☐ Low Back Pain ☐ Other:____________________

What caused this complaint?____

____

When did this begin? ___/_____/_____ **Is it getting worse?** ☐ Yes ☐No ☐Constant ☐Comes & Goes

Have you had similar pain in the past? ☐ Yes ☐ No **If "Yes", when?** _________________________

What does your complaint feel like? (Circle all that apply) *Sharp / Dull / Sore / Stiff / Tight / Aching*

Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness

Other: ____

Are you interested in learning more about dry needling? ☐ Yes ☐ No

On the scale below, please circle the severity of pain for your main complaint:

No Pain Moderate Pain Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

HEALTH HISTORY

List current medications including frequency and dosage (if known). If NONE, check here ☐

___

List any know allergies:___

Please check ALL of the health conditions below that apply to you now or in the past.

☐ Diabetes - ☐ Type I ☐ Type 2 Was your blood/lab work for hemoglobin A1c>9.0%? ☐ Yes ☐ No ☐???

☐ Cancer/Tumor ☐ Osteoarthritis/Degenerative Joint Disease ☐ Asthma ☐ Anemia

☐ Disc Herniation ☐ Rheumatoid Arthritis ☐ Depression/Anxiety ☐ Headaches

☐ Migraines ☐ Oseoporosis/Osteopenia ☐ Epilepsy/Seizures ☐ Fibromyalgia/Chronic Fatigue

☐ Heart Disease/Stroke ☐ High Blood Pressure/Hypertension

☐ Whiplash Injury (Date:___) ☐ Genetic Disorders ___

☐ Joint Pain (location of pain: ☐ Shoulder ☐ Elbow ☐ Hip ☐ Knee ☐ Ankle ☐ Other:___

Family History	Relationship	Family History	Relationship
Cancer		High Blood Pressure	
Anemia		Genetic Disorders	
Diabetes ☐ Type 1 ☐ Type 2		Rheumatoid Arthritis	
Heart Problems/Stroke		Other:	

Trauma: (broken bones, sprains, strains, major trauma/injury): (list and date): ___

___

Surgeries and/or Hospitalizations (list and date): ___

___

Have you ever had an X-ray, CT scan or MRI of your low back? ☐ Yes ☐ No **Date(s):** ___

SOCIAL HISTORY

Do you exercise? ☐ Yes ☐ No **Times per week?**___ **Intensity?** ☐ Light ☐ Moderate ☐ Intense

Type of exercise:___

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker

INSURANCE INFORMATION

Type of Insurance: ☐ Private ☐ Medicare ☐ Auto Insurance ☐ Worker's Comp ☐ Other:___

Primary Insurance Carrier:___ **Phone:**___

Policy Number:___ **Group #:**___ **Claim #:**___

Name of Policy Holder:___ **Relation to Patient:**___

Policy Holder's Birthdate:__/___/___ **Policy Holder's SSN:**___/___/___

Secondary Insurance Carrier: ___ **Policy Number:**___

Patient Responsibility Form

Insurance Coverage

- **It is your responsibility** to be aware of your insurance coverage, policy provisions, exclusions, and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. We will use the information provided by your insurance company, however, this information is limited and occasionally inaccurate. Ultimately, the financial responsibility for payment for services rendered is yours.

Insurance Changes

- If you have **ANY** changes in your insurance coverage – even if there is only a small change – you must notify us. Failure to do so may result in denial of your claim which would then be your responsibility.

Co-payments, Co-insurance, and Deductibles

- **Patients are responsible for the payment of copays, coinsurance, deductibles, and all other treatments not covered by your insurance coverage.**
- Payment is due at the time of service and for your convenience, we accept cash, credit cards, and checks (you are responsible for returned check fees) at our office.

Insurance Request

- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial, making you responsible for payment.

Collection Accounts

- In the case your account is referred to a collection agency, you are responsible to pay all fees if applicable.

Missed Appointments – the below will be enforced at office discretion based on the reason for cancellation/missed appointment and previous history.

- You will incur a no-show fee of $50.00 if you do not show up for scheduled appointments.
- All appointments require a 24-hour cancellation notice, or you will be charged $50.00.
- Arriving late to an appointment may require rescheduling which could incur a late cancellation fee of $50.00.

Refusal of Service – Heppe Chiropractic reserves the right to refuse service based solely on our judgement and may do so at any time. This could be for chronic missed appointments, refusal to pay, misconduct with staff, or any other reason we deem appropriate. We do not owe an explanation for our decision to refuse service.

Signature:____ Date:___________________

Patient Authorizations

I certify that I, and/or my dependents, have insurance with the below named insurance company(s) and assign directly to Heppe Chiropractic, LLC all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "copays, coinsurance or deductibles are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above-named provider's office may use my health care information and may disclose such information to the below- named insurance company(s) for the purpose of obtaining payment for services and determining benefits payable for related services.

No Insurance/ Private Pay: ☐ By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility From:

Name of Person Responsible for this account:_______________________________

Signature:____ Date:___________________

INFORMED CONSENT

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 primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment: As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, traction, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, EMS, ultrasound, hot/cold therapy, radiographic studies, A.R.T, Graston, flexion-distraction, cupping, dry needling.

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation 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 treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. 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.

DO NOT SIGN UNTIL YOU HAVE READ AND 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 will not hold my doctor or any staff member at Heppe Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print Name:______________________________________ **Witness:**______________________________

Signature:_______________________________________ **Signature:**____________________________

Date: ______/_____/______ **Date:** ______/_____/______