Dr. Steve Fleisher
Chiropractor

198 Allendale Rd., Ste 201, King of Prussia, PA 19406
(610) 337-3700
DrSteve@helpmedrsteve.com
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NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____

E-Mail:_____ Social Security #_____

Phone: Home: _____ Cell: _____ Work: _____

Marital Status: M/P/W/D/S Birthdate:_____/_____/_____ Age: _____

Whom may we thank for referring you?_____

Your prior Doctor of Chiropractic: _____

and address_____

Chiropractic techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner:_____ and City: _____

Your Employer: _____ Phone Number: _____

Employer's Address: _____

Occupation: _____

Spouse's Name: _____

Spouse's Employer:_____

Children's Name & Ages:_____

Favorite Hobbies or Interests: _____

Health Reasons for Consulting Our Office:

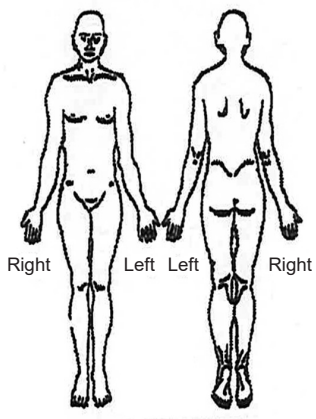
1. _____

2. _____

3. _____

4. _____

Mark areas of Health Concerns



Have you had the same or similar problem(s) before? Yes__

How Long: _____

Please explain: _____

_____

Father/Mother/Brother/Sister/Children, with similar problems? _____

_____

Is this the result of an auto or work injury?_____ If so, when?_____

If this is a work injury, is there a panel chiropractor that your company's Worker's Compensation Insurance requires you to see in the first 90 days? If so, please list their name. _____

_____

Other Doctors who have treated this problem: _____

_____

Surgery you have had: _____

Medication(s) you currently take:_____

Is there any chance your are pregnant? Yes_____ No _____

What have you heard about chiropractic?_____

_____

Do you know what a subluxation is? _____ If yes, please describe _____

_____

Have you ever been diagnosed with cancer? _____If so, what kind? _____

_____

Do you have health insurance? Yes _____ No _____

Name of Company: _____

I.D. #: _____

Provider's Phone # _____

Name of Insured _____

Address to Send Claims _____

Method of Payment for First Visit: Cash_____ Check_____ Credit Card _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If I fail to pay for services rendered and you are required to institute collection proceedings, I agree to pay for reasonable attorney's fees and costs in attempting to collect the balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____

Date: _____

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried may of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

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HEALTH CARE AUTHORIZATION FORM

This serves as notice that Everybody's Chiropractic & Wellness Center, it's employees and outside contractors are in compliance with federal guidelines regulating patient privacy.

Patient's Name:_____

Patient's SS#:_____ Date of Birth:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** to use my address, phone number, e-mail address and clinical records to contact me with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information.

I give permission to **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** to use my name on sign in sheets, and "patient of the week" award certificates, should the occasion arise. X-rays, personal and family photographs and patient testimonials documenting the many successes of chiropractic care may also be displayed with the patient's permission.

I give **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** 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 the doctor at any time in private, the doctor will provide a room for these conversations.

I give **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** permission to obtain any testing results and/or medical records on my behalf.

Cross out any you don't want.

EXPIRATION

This authorization will expire seven years after the date on which you last received services from us.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this 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 **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER**. The hand 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 authorization;
The date of your request;
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** for its own use/disclosure of PHI. (Minimum necessary standard apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **EVERYBODY'S CHIROPRACTIC & WELLNESS CENTER** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

** a copy of the signed authorization will be provided to you **

_____

Name of Patient

_____

Signature of Patient Date

_____

Signature of Personal Representative Date

_____

Description of Representative's Authority to Act for Patient

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. 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, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____

Patient Name Printed

_____

Patient Signature Date

_____

Guardian of a Minor Signature Date