Peak Performance
CHIROPRACTIC

Date: _____ Referred By: _____

Patient Name: _____Social Security #:_____

Home #: _____Cell #: _____Work #: _____ Email: _____

Birth Date: _____Address: _____City/State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Employer Address: _____City: _____State:_____ Zip Code: _____

Marital Status: ☐ Married ☐Single ☐ Divorced ☐ Widowed Number of Children: ____

Spouse's Name: _____DOB: ____/_____/_____Social Security #: _____

Employer: _____Work Address: _____

Have you previously had Chiropractic Care? _____ If yes, when? _____Did it help? _____

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Please describe work activities that may be causing you complaints: _____

Please explain any other activities outside of work, which may have caused these complaints: _____

If this is due to an injury or accident, when did it happen? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

Have you been involved in an auto accident in the last 12 months? _____

Do you have Health insurance? _____ Name of Insurance Company? _____

Are you covered under additional (group or individual) health policy through yourself or spouse? _____

Name of insurance of additional coverage: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Ronald Bittle all insurance benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claim submission.

Responsible Party's Signature: _____ Relationship to patient _____ Date: _____

Are you taking any medication? ☐ Aspirin ☐ Birth Control ☐ Insulin ☐ Tranquilizer ☐ Other: _____

_____

Were you aware that:

1.	Doctors of Chiropractic work with the nervous system?	☐ Yes	☐ No
2.	The nervous system controls all bodily functions and systems?	☐ Yes	☐ No
3.	Chiropractic is the largest natural healing profession in the world?	☐ Yes	☐ No
4.	If Chiropractic care starts at birth: you can achieve a higher level of health throughout life?	☐ Yes	☐ No

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program for care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ RELIEF CARE: Symptomatic relief of pain or discomfort

☐ CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms.

☐ COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health with Chiropractic care.

☐ I want the Doctor to select the type of care appropriate for my condition.

Patient Signature: _____

Peak Performance
CHIROPRACTIC

Chiropractic Informed Consent

I hereby request and consent to the performance of procedures from any doctor of **Peak Performance Chiropractic,** including various modes of chiropractic care, diagnostic, x-rays, and any supportive procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below, and/or other licensed doctors or chiropractic, and support staff who now or in the future care for me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand and I am informed that, as is with all healthcare procedures, results are not guaranteed and there is no promise to cure. I further understand that I am informed that, as is with all healthcare procedures, in the practice of chiropractic, there are some risks with treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement with symptoms, fractures, disc injuries, strokes, dislocations, and sprains.

I further understand that Chiropractic adjustments and supportive care is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. I understand that all payment(s) for care are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if a request to cancel the treatment is made with written notice.

I further understand that there are other health-care options available for my condition other than chiropractic procedures. I understand that I have the right to a second opinion and may secure other options if I have concerns as to the nature of my symptoms and/or the doctor's recommendations.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____ Date: _____

Signature of Patient: _____

Name of Guardian/Parental: _____ Relationship to Patient: _____

Guardian/Parental Signature: _____ Date: _____

Name of Doctor of Chiropractic: _____ Date: _____

Signature of Doctor of Chiropractic: _____

I have had an opportunity to discuss with the doctor or chiropractor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. _____ (Initial)

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to work for the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate ability to maintain peak health. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I**, _____** have read and fully understand the statements above.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ **_____**

Signature Date

Consent to evaluate and adjust minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual cycle. _____

_____ _____

Signature Date

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPPA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your protected health information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time; although any services performed prior to the revocation of this consent is covered by this consent.

Patient Signature: _____ Date: _____

Restrictions:

Right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practice will be applied to all protected health information we maintain.

Doctor/ Staff Signature: _____ Date: _____

Peak Performance
CHIROPRACTIC

Professional Fee Schedule

Health History Intake	**No Charge**
Chiropractic Examinations	**$85 to $175**
Chiropractic Office Visits	**$35 to $100**
Chiropractic X-ray Studies	**$44 to $152**
Doctor/Patient Consultation	**$85**
Thermograph	**$165**

(All fees are standard and primarily based on our professional association's guidelines.)

Our experience has shown that it is important to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment, and you may choose the plan which best fits your needs. This information will enable us to better serve you and help to avoid misunderstanding in the future. If special arrangements are necessary please let us know. Our main concern is your health and well being, and we will do our best to help you.

Plan #1- General Health Insurance: If you have insurance that covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance card on or before your second visit. Until we have the completed, necessary insurance information to verify Chiropractic coverage, you will be required to pay for your care. After we verify your insurance company's benefit details, we will discuss them with you. Most insurance companies will not cover "maintenance" care and therefore, we can offer other arrangements if your condition requires further care beyond your insurance limits.

Plan #2- Private Pay/Cash: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. If a check is accepted for payment and it is declined, our office will add a LATE FEE of $20 that will be added to the original charge. This fee also applies to any payment that was not paid at the time of service.

Plan #3- Industrial (work-related) Injuries: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

Plan # 4- Auto Injury: You need to supply us with the accident report, your car insurance, health insurance, liable party's insurance, and attorney information(if applicable). Until Necessary insurance information is gathered and benefits verified, you will be required to pay for your care. We will bill your insurance information directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

I qualify for, and understand, Plan # _____requirements.

Signature: _____ **Date: _____**