PATIENT CHIROPRACTIC REGISTRATION

VERONICA SLAUGHTER, D.C.
74040 EL PASEO, STE. D PALM DESERT, CA 92260
PHONE: 760-340-4157 FAX: 760-568-2915

1) PATIENT DEMOGRAPHIC INFORMATION

Last Name:	**First Name:**	MI:	**Date of Birth:**	Age:	**Sex:** ☐ Male ☐ Female
Spouse's First Name:	Your Preferred First Name:		**Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Minor		
Mailing Address:			**Address Status:** ☐ Permanent ☐ Seasonal		**Local Home Phone :** ( )
City:	**State:**	**Zip Code:**	**Best way to reach you:** ☐ Home ☐ Cell ☐ Work		**Cell Phone:** ( )
Alternate Address (if mailing address is seasonal):			Alternate address duration:		Alt. Home Phone: ( )
City:	State:	Zip Code:	**E-mail Address:**		
Employment Status: ☐ Retired ☐ Employed ☐ Student ☐ Unemployed	Employer: Job Title:				Work Phone: ( )
Referred by: ☐ Family ☐ Friend ☐ Insurance Co. ☐ Health Care Professional ☐ Close to home/work ☐ TV ☐ Yellow Pages ☐ Online Search ☐Other			Specific Referral Source:		
Other family members who are patients:					

2) IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to Patient:**	**Phone:** ( )

3) PAYMENT INFORMATION

Primary Responsibility (check one below and provide additional information if applicable)

☐ Self	Note: Payment is due at Time of Service	
☐ Medicare	Is there a secondary or supplemental insurance? ☐ Yes ☐ No	
☐ Health Insurance	Is there a secondary insurance? ☐ Yes ☐ No	
☐ Auto Insurance	Who's insurance? ☐ Patient's ☐ 3rd party	Accident Date:
☐ Workers' Compensation	Social Security Number:	Accident Date:
☐ Other Guarantor	Name:	☐ Parent ☐ Employer ☐ Atty ☐ Other
	Guarantor Address:	Phone: ( )

The information provided on this form is true to the best of my knowledge and I will inform you of any changes in my health, demographics or insurance when applicable. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by insurance. I also authorize this office or my insurance company to release information required to process my claims and that, otherwise, it will be kept confidential in accordance with state law.

_____ _____

Patient/Guardian signature ***Date***

PATIENT CHIROPRACTIC REGISTRATION – VERONICA SLAUGHTER, D.C.

Patient Name:	**Date:**

4) GENERAL HEALTH HISTORY

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No	**Primary Care Doctor:**

Patient History: Place a mark in the box next to each condition you have or have had in the past. ☐ None apply ☐See attached

☐ AIDS/HIV	☐ Heart Disease	☐ Migraine Headaches	☐ Fractures
☐ Allergies	☐ Hernia	☐ Osteoporosis	☐ Pregnant – Due Date:
☐ Arthritis	☐ Herniated Disk	☐ Pacemaker	☐ Stroke
☐ Corticosteroid Use	☐ High Blood Pressure	☐ Pinched Nerve	☐ Thyroid Problems
☐ Diabetes	☐ High Cholesterol	☐ Prosthesis	☐ History of Low/Mid Back Pain
☐ Dizziness/Fainting	☐ History of Neck Pain	☐ Prostate Problem	

Family History: ☐ Cancer ☐ Cardiovascular Problems ☐ Diabetes ☐ High Blood Pressure ☐ None apply

Relevant Incidents	**Description**	**Date**
☐ Recent Fall or Injuries		
☐ Surgeries		

Exercise:	**Work Activity:**	
☐ None ☐ Occasional ☐ Regularly ☐ Daily	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	

5) CURRENT SYMPTOMS

How long have your symptoms been going on?

How did your symptoms begin?

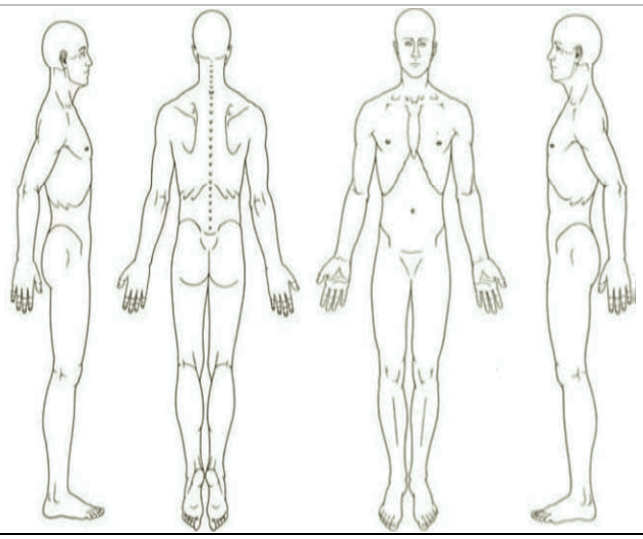
What activities does your pain interfere with?

How often do you experience your symptoms?
☐ Constantly (76-100%) ☐ Frequently (51-75%)
☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What relevant imaging tests have you had done?
☐ None ☐ X-rays ☐ MRI ☐ CT Scan

Who have you seen for your symptoms? ☐No One ☐ M.D.
☐Other Chiropractor ☐ Physical Therapist ☐ Acupuncturist

Use diagram below to identify where you have pain.



Rate how you feel today. No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐ 7 ☐8 ☐9 ☐10 Unbearable Pain

OFFICE POLICY – VERONICA SLAUGHTER, D.C.

Patient Name (please print): _____

1) MEDICAL RELEASE

I hereby authorize any physician, hospital or other medically related institution or facility that has medical and/or imaging records pertaining to me or my health, including prior medical history, to **release such records to Veronica Slaughter, D.C**. A photocopy of this authorization shall be considered as valid as the original.

SIGNATURE: _____ **DATE:** _____

2) ACCOUNT RESPONSIBILITY

I agree to **notify the office immediately whenever I have changes** to my contact information, my insurance coverage, or my health condition. I understand that **I am liable for all charges for services rendered,** regardless of insurance coverage, and that **co-pays and self-pay payments are due at time of service.**

NOTES:

- If your health insurance has a deductible or pays a percentage, we may estimate your responsibility per visit and collect at time of service. After claims have been processed, we will bill you for any balance due and any credit amounts will be refunded or applied towards future services (per your request).
- If you discontinue care for any reason without the authorization of the doctor, the balance of your account is due and payable in full immediately.

SIGNATURE: _____ **DATE:** _____

3) INSURANCE ASSIGNMENT

I authorize direct payment of all medical benefits to Veronica Slaughter, D.C., to which I am entitled, including private insurance and any other health benefit plan, except Medicare. I also understand that my insurance policy is an arrangement between myself and my insurance carrier and there is no guarantee that they will pay. **If for some reason claims are denied, I am responsible for the full amount of my bill.**

SIGNATURE: _____ **DATE:** _____

NOTES:

- If we are unable to verify your insurance on or before your first visit, you will be responsible for the self-pay rates until verified.
- Waiting for insurance payment is a courtesy and may be withdrawn, if circumstances warrant. If your insurance has not paid within 60 days, you must pay the balance. We do not enter into disputes over your claims.
- **Dr. Slaughter <u>does not</u> accept assignment for Medicare.** Payment will be due at time of service. We will bill Medicare and they should reimburse you according to their guidelines. If you have a secondary or supplemental insurance, Medicare should automatically crossover the claim to that insurer and they should reimburse you accordingly. If you receive an Explanation Of Benefits (EOB) that indicates the doctor was paid instead of you, please bring a copy of that EOB and we will gladly reimburse you. (**Office Use Only: □ MRA01**: _____)

4) CONFIDENTIALITY STATEMENT

Unless its release is authorized by the patient or compelled by law, **all information about the patient gathered by our office as part of the doctor patient relationship will be kept confidential.** Policies and procedures are in place to address data security, privacy, and confidentiality of paper and electronic records in conformance with state law.

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

Dr. Veronica Slaughter
74040 El Paseo Ave. Ste. D
Palm Desert, CA 92260
(760) 340-4157
www.desertthealing.com

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name	**Signature**	**Date**
Witness Name	**Signature**	**Date**