Louisville
HEALTHSOLUTIONS
CHIROPRACTIC – REHAB – WELLNESS

PATIENT INFORMATION & CONDITION FORM

PATIENT NAME: _____ Today's Date: ___/___/___

Preferred Name or Nickname:_____

How did you hear about us? _____

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian? _____Phone: (____)_____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Cell Phone Number (_____) _____

Your Occupation _____ Employer _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____ Phone (____) _____

INSURANCE

Do you have health insurance? ☐ YES ☐ NO Insurance Company: _____

CONDITION

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Date of accident: ____/____/____

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO Please check ALL that apply.

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

Approximately, when did your injury or condition occur? ___/___/____

*Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Describe your pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness

On a scale of 1-10, 10 being the worst, how would you rate your pain?_____

What caused it? _____

What aggravates it? _____

What relieves it? _____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Date of last physical examination? _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Do you have a pacemaker? ☐ Yes ☐ No

What surgery have you had? _____ When? _____

Illnesses or conditions:

_____

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/_____/_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Name:_____

PURPOSE OF CONSENT

The purpose of this form is to obtain your consent to receive chiropractic care, including examinations, diagnostic procedures, and therapeutic treatments, provided by your chiropractor or their associates.

NATURE OF CHIROPRACTIC TREATMENT

Chiropractic treatment may include the following procedures:

- Spinal and extremity adjustments or manipulation
- Soft tissue techniques
- Physical therapy modalities (e.g., ultrasound, electrical stimulation)
- Rehabilitative exercises
- Postural and lifestyle advice
- Nutritional counseling

RISKS OF TREATMENT

As with all health care procedures, chiropractic treatment carries potential risks, including but not limited to:

- Temporary soreness or discomfort
- Dizziness or lightheadedness
- Bruising or swelling
- Muscle strain or ligament sprain
- Aggravation of pre-existing conditions

Rare complications, although highly uncommon, may include:

- Rib fracture (in osteoporotic patients)
- Disc herniation or aggravation
- Nerve damage
- Stroke (associated with neck manipulation, though extremely rare)

You are encouraged to discuss any questions or concerns with your chiropractor before beginning treatment.

BENEFITS OF CHIROPRACTIC CARE

Chiropractic care has been shown to be effective in treating various musculoskeletal conditions, such as:

- Neck and back pain
- Headaches
- Joint and muscle dysfunction
- Sciatica
- Improved range of motion and function

ALTERNATIVE TREATMENT OPTIONS

Alternatives to chiropractic care may include:

- Medical care (e.g., prescription medication, physical therapy)
- Orthopedic care
- Acupuncture
- Surgery (in extreme cases)

PATIENT RIGHTS

You have the right to:

- Withdraw consent and discontinue care at any time
- Ask questions and receive answers about your treatment
- Receive information in terms you understand

ACKNOWLEDGEMENT AND CONSENT

I understand that chiropractic care involves some risks and that results are not guaranteed. I acknowledge that I have had the opportunity to discuss the nature, purpose, benefits, and risks of chiropractic treatment. I have read and fully understand this consent form.

I consent to chiropractic evaluation and care as recommended by my chiropractor.

SIGNATURE:_____ **DATE:**_____

NOTICE OF PRIVACY PRACTICES

Name:_____

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

Our Responsibilities
We are required by law to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices.
- Abide by the terms of the current notice.

How We May Use and Disclose Health Information
We may use and share your health information for:
Treatment
To provide, coordinate, or manage your healthcare and related services.
Payment
To obtain reimbursement for your healthcare services, confirm insurance coverage, or bill and collect payment.
Healthcare Operations
To improve our services, train staff, and conduct quality assessments.

Other Uses and Disclosures
We may also use or disclose your information in the following situations:

- When required by law
- For public health and safety
- For health oversight activities
- For judicial and administrative proceedings
- To law enforcement
- To avoid a serious threat to health or safety
- For workers' compensation claims
- For research purposes (under strict guidelines)

Your Rights
You have the right to:

- **Get a copy of your medical record**
- **Correct your medical record**
- **Request confidential communications**
- **Ask us to limit what we use or share**
- **Get a list of those with whom we've shared your information**
- **Get a copy of this privacy notice**
- **Choose someone to act for you**
- **File a complaint if you feel your rights are violated**

Complaints
If you believe your privacy rights have been violated, you can file a complaint with:

- PRIVACY OFFICER: NICOLE ANDERSON
- (502) 423-0500 OR (502) 633-1574

You will not be penalized for filing a complaint.

Contact Us
If you have any questions about this notice or need more information, please contact our office.

SIGNATURE:_____ **DATE:**_____