WEST MICHIGAN CHIROPRACTIC

**REGISTRATION FORM**

## Personal Information

Name: _____ Date: _____/_____/_____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Cell Phone Carrier: _____Work Phone: _____

Social Security #_____ Birth Date: _____/ _____/_____

Please circle one: Male / Female Married, Single, Widowed, Divorced

How did you hear about us? _____

Email Address: _____Work Email: _____

Other family member's names: _____

## Insurance Information

**(Please give your insurance card and driver's license to the front desk for a complimentary benefits evaluation)**

Primary Insurance Carrier: _____ Subscriber's Name: _____

Occupation: _____Employer: _____

Subscriber's S.S. # _____ Birth Date: ____/_____/_____

**Insurance Policies and Fee Schedules**

- **Consultation-**includes practice member history. This service is complimentary.
- **Examination (new patient or established patient)-**includes one of more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $50-$75.
- **Chiropractic Adjustment –** The actual re-alignment of the vertebra. A specific instrument is used to make the spinal adjustment. 1 to 3 specific adjustments will be made per visit, re-aligning the vertebra. $40-$60.
- **X-rays –** Specific x-ray views taken of your spine to determine a misalignment/subluxations of your vertebrae. These can also be used to indicate progress after period of care $40 per view.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Sarah Malarney, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other Arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed _____ Date _____

**Health Information Form**

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Who can we thank for referring you here today? _____

Have you ever been to a Chiropractor before? Y / N

**Health Concerns:**

| Health Concerns: In Order of Importance | Severity 1=Mild 10=Unbearable | How long have you had this? | Did this start with an injury? | Have you had this before? | Is this constant or comes/goes? |
|---|---|---|---|---|---|
| 1._____ | _____ | _____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ | _____ | _____ |

**On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____**

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?_____

_____

**Main Complaint History:**

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No Describe: _____

3. How often is this present?

☐ Constant (81 – 100%) ☐ Frequent (51 – 80%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____

5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Lying Down ☐ Other

If other, please explain: _____

6. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _____

_____

7. Please list all medications you are taking and for what:

_____

_____

_____

8. Please list any broken bones, surgeries or hospitalizations you have had and when:

_____

_____

9. Please list any auto accidents you have been involved in:

_____

_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD/MONOR

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DRS. SARAH AND RYAN MALARNEY AND ANY AND ALL WEST MICHIGAN CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY WEST MICHIGAN CHIROPRACTIC.

Guardian Signature _____ Date _____

Guardian's Relationship to Minor/Child _____

Witness Signature (Office Staff) _____

10. Please check off any of the conditions below that you (or your family) have or have had in the past:
**-- Write C if current issue or P if past issue**

| | Yourself | Spouse | Children | Mother | Father |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Arthritis | | | | | |
| TMJ | | | | | |
| Acid Reflux | | | | | |
| Epilepsy | | | | | |
| Ulcers | | | | | |
| Dizziness | | | | | |
| Headaches | | | | | |
| Vertigo | | | | | |
| Nervousness | | | | | |
| Menstrual Irregularity | | | | | |
| Nausea | | | | | |
| Lupus | | | | | |
| Fatigue | | | | | |
| Numbness | | | | | |
| Ear Infections | | | | | |
| Sciatica | | | | | |
| Cardiac Condition | | | | | |
| Migraines | | | | | |
| Sinus | | | | | |
| Kidney Condition | | | | | |
| Liver Disease | | | | | |
| Fainting | | | | | |
| Disc Problems | | | | | |
| Stiffness | | | | | |
| Irritable Bowel | | | | | |
| Stomach Condition | | | | | |

# TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

**HEALTH:** A 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 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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

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

I therefore accept chiropractic care on this basis.

Signature _____ Date _____

## Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

# X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

**PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF WEST MICHIGAN CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

**BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS**

PRINTED NAME _____ DATE _____

SIGNATURE _____ YOUR AGE _____

**FEMALE PATIENTS ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT WEST MICHIGAN CHIROPRACTIC

SIGNATURE _____ DATE _____

**DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE**