INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic LLC, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through a chiropractic adjustment. This is a specific manual force applied to the spine by hand or instrument, in which a controlled thrust or impulse is delivered to the involved area. The doctor may need to touch sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that techniques may require the body to be placed into awkward positions to better receive treatment. I request and consent to receiving chiropractic care, diagnostic X-rays, and other related therapies, on myself (or on the patient for whom I am legally responsible) by any licensed doctor of chiropractic employed at Compass Chiropractic LLC.

Many patients report benefits while under chiropractic care including increased range of motion and pain relief. Although most people respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there are some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated at one in two million and can be further reduced by screening procedures. Complications generally result from underlying other pre-existing conditions. I understand that a risk exists.

I am ultimately responsible for my health and therefore may seek care from other related health care fields. Common alternatives to chiropractic treatment consist of acupuncture, massage therapy, physical therapy, and orthopedic evaluation. Each of these have their own risks and benefits. I am free to discuss any questions or concerns with the doctor as the need arises, especially during my first visit. Based this information, I understand the nature of treatment, its risks/benefits, and that other alternatives exist for me to pursue.

I have read this document and give my consent to receive chiropractic treatment. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions.

Patient Name (Printed): _____

Patient or Guardian Signature: _____ Date:_____

Females Only - Regarding Possibility of Pregnancy

X-rays, particularly those involving the lumbopelvic region, can be hazardous to an unborn child. It is advisable that, in women of child-bearing potential, X-rays be taken only in the first ten (10) days following the onset of a menstrual cycle, as this is generally considered to be safe for X-ray exams. With this in mind, I certify that to the best of my knowledge I am NOT pregnant, and the doctor has permission to perform diagnostic X-rays. It it my responsibility to update the treating doctor if this status changes.

Initial:_____

HIPAA - Notice of Privacy Policy

Our Notice of Privacy Practices provides information about how we may use and disclose “protected health information” (PHI) about you. A summary is below, and our full privacy statement is made available on the practice website: www.CompassChiroVA.com.

* Our office does not distribute or make available to any outside source your PHI except in cases of treatment or referrals, claims submission to third party insurance carriers for the purposes of payment, and other health care operations (subpoena of records).
* A family member may be present during your visit, but your PHI will not be available to them without your written authorization.
* Our office may utilize, text, phone, or email reminders to confirm or reschedule an appointment.
* We may leave a voicemail at the phone number provided unless you have specifically instructed us to the contrary.
* You have the right to withdraw consent and terminate care at any time for any reason. Withdrawals of consent must be in writing.

Patient or Guardian Signature: _____ Date:_____

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Assignment of Insurance Benefits

I, _____, assign and direct that payment be made directly to:
(Printed Name)

COMPASS CHIROPRACTIC LLC
13146 MIDLOTHIAN TURNPIKE
MIDLOTHIAN, VA 23113

for any and all insurance benefits or reimbursement of services rendered by Compass Chiropractic LLC which amounts would otherwise be payable to me under my insurance or pre-paid health plan.

I further understand that if my insurance carrier mistakenly sends payment to me for services incurred in this office, I agree to surrender those payments upon receipt.

Patient or Guardian Signature: _____ Date:_____

Financial Policy

There is no guarantee that your insurance company or pre-paid health plan will cover or pay for charges you incur. In the event of denied claims, reduction of benefits, or failure of my insurance company to pay for any reason, you are responsible for all remaining charges. This is so even if the results of your treatment are not as expected.

General Information:
All deductibles, co-insurances, and copayments are due at the time of service.
It is your responsibility to notify us of any changes to your health insurance.
Our office will provide whatever treatment is necessary to help your condition or complaint, regardless of what your insurance coverage is or what they consider to be medically necessary. You are responsible for these balances.

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for any and all collection costs, include reasonable attorney's fees.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy assesses a $15 fee for missed appointments and a $30 fee for missed new patient appointments. We strive to have little to no wait time for all visits, and this can only be accomplished if you keep your appointments or provide notice of changes.

I have read, understand, and agree to this financial policy.

Patient or Guardian Signature: _____ Date:_____

Compass Chiropractic LLC

Pediatric Health Profile

A Parent/Guardian must fill this out if the child is under 12 years old.

Welcome to Compass Chiropractic! We look forward to working with you and your family. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay, even if there is no pain. A chiropractor checks for painless spinal misalignments that damage the nerves. Our focus is on removing this nervous system interference, allowing your child's body to express health naturally.

Demographic Information:

Full Name: _____ Date of Birth: _____

Mailing Address: _____

Age: _____ Years _____ Months _____ Weeks Height/Length: _____

Grade: _____ Weight (lbs): _____

Parent/Guardian Information:

Full Name: _____ Phone: _____

Mailing Address (if different): _____

Relationship to Patient: _____ Email: _____

How did you hear about us/Who referred you? _____

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or other members of your family:

Self: _____ Spouse: _____

Other Children: _____ Other: _____

Prenatal History: this section applies only to children 6 and under

Any complications during pregnancy? ❑ No ❑ Yes, _____

Birth Type: ❑ Home ❑ Birthing Center ❑ Hospital Labor length: _____hours

Gestational age at birth: ❑ Under 37 weeks ❑ 37-42 Weeks ❑ Over 42 weeks

Any complications during the delivery? ❑ No ❑ Yes, _____

Any congenital anomalies/birth defects? ❑ No ❑ Yes, _____

Delivery Method (check all that apply): ❑ Vaginal ❑ Forceps ❑ Vacuum Extraction ❑ Cesarean-section

Feeding History:

Breast-fed? ❑ No ❑ Yes How long? _____

Formula-fed? ❑ No ❑ Yes Age when he/she was first introduced? _____ Months _____ Weeks

Does or did your baby consistently prefer feeding more on one side than the other? ❑ No ❑ Yes, _____

Introduced to solid foods at: _____ Months ❑ Not yet been introduced to solid foods

Introduced to cow's milk at: _____ Months ❑ Not yet been introduced to cow's milk

Medical History:

Doctor/Pediatrician Name: _____ Last Visit: _____

Office/Clinic Name: _____ Town: _____

Hospitalizations/Surgeries: check all that apply and explain below

❑ Spine ❑ Brain ❑ Heart ❑ Lung ❑ Hip (R/L) ❑ Shoulder (R/L)

Age: _____ Area: _____ Procedure: _____

Age: _____ Area: _____ Procedure: _____

Accidents/Injuries: includes car accidents, serious falls, sports injuries, broken bones, etc.

Age: _____ Area injured: _____ How? _____

Age: _____ Area injured: _____ How? _____

Allergies? ❑ No ❑ Yes, _____

Medication(s): please list all over-the-counter or prescription medications taken in the last year

Medication	Reason	Current or Past

Family History: this refers only to siblings, parents, and grandparents

❑ Seizures ❑ Diabetes ❑ Kidney Disease ❑ Other: _____

Social History:

Does your child play any contact sports (wrestling, football, gymnastics, etc.)? ❑ No ❑ Yes, _____

Does your child avoid or fear social environments with other children? ❑ No ❑ Yes, _____

Vaccination History: ❑ Declined vaccinations ❑ Up to date on all vaccinations ❑ Still deciding

Please describe any adverse reactions to vaccinations: _____

Has your child been to a chiropractor before? ❑ No ❑ Yes, Last Visit: _____

Systems Review: has your child ever had a problem with any of the following? Check all that apply.

General
❑ Cancer
❑ Recurring fevers
❑ Eczema/Rashes
❑ Excess TV/Video games
❑ Personality changes

Neurological
❑ Seizures
❑ Headaches
❑ Numbness/Tingling
❑ Bed wetting
❑ Delayed potty-training

Gastrointestinal
❑ Reflux
❑ Colic
❑ Jaundice
❑ Constipation
❑ Food Sensitivity (Gluten, Dairy)

Developmental
❑ Autism
❑ Asperger's
❑ Difficulty concentrating
❑ ADD/ADHD
❑ Other: _____

Musculoskeletal
❑ Neck stiffness
❑ Hip disorders
❑ Difficulty walking
❑ "Growing" pains
❑ Broken bones

EENT
❑ Ear infections
❑ Frequent colds/flu
❑ Persistent cough
❑ Asthma
❑ Allergies

Female Only
❑ First period before age 12
❑ Irregular bleeding pattern
❑ Menstrual cramping
❑ Inconsistent cycle lengths
❑ Pain during cycle
❑ Use of birth control

Primary Complaint:

What is the main reason for your child's visit? ❑ Wellness check ❑ Specific Problem(s), fill in below.

_____

_____

Do you think your child's current diet, environment, or physical activity level contributed to their problem(s)?
❑ No ❑ Yes, please explain: _____

_____

When did this first start? _____ ❑ Started suddenly ❑ Started gradually

The problem is on the: ❑ Right ❑ Left ❑ Both sides ❑ N/A

The problem is: ❑ Constant ❑ Frequent ❑ On and off ❑ Occasional

How severe is this problem on a scale of 1-10, with 10 being the worst: _____ /10

What have you found makes this problem better or worse? _____

This problem is interfering with (check all that apply):

❑ School ❑ Sleep ❑ Concentration ❑ Daily Routine ❑ Playing/Recreation ❑ Family cohesion

Signatures:

Did we miss something? Please indicate if there is anything else you would like us to know about your child.

_____

_____

_____

I have read and completed the information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide my child with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Parent/Guardian: _____ Date: _____