

HERRING CHIROPRACTIC CLINIC CHIROPRACTIC HEALTH PROFILE

Name _____ Date____/____/____ Age_____ Male/Female
Address _____ City_____ State_____ Zip_____
Phone: Home _____ Cell _____ Cell Phone Provider _____
Email Address _____ Date of Birth____/____/____
Occupation _____ Employer's Name _____
Single / Married / Divorced / Widowed Spouse's Name_____
Number of Children_____ Names, Ages & Gender_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO
CHIROPRACTOR? _____ MEDICAL DOCTOR? _____ OTHER_____
WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

<i>DIZZINESS</i>	<i>THROAT ISSUES</i>	<i>KIDNEY PROBLEMS</i>	<i>LIVER DISEASE</i>	<i>NERVOUSNESS</i>
<i>HEADACHES</i>	<i>THYROID PROBLEMS</i>	<i>MID BACK PAIN</i>	<i>SHOULDER PAIN</i>	<i>EPILEPSY</i>
<i>VERTIGO</i>	<i>ASTHMA</i>	<i>IRRITABLE BOWEL</i>	<i>CHRONIC FATIGUE</i>	<i>DISC PROBLEM</i>
<i>EAR INFECTIONS</i>	<i>ULCERS</i>	<i>SCIATICA</i>	<i>LUPUS</i>	<i>INFERTILITY</i>
<i>NAUSEA</i>	<i>NUMBNESS IN ARMS</i>	<i>NUMBNESS IN LEGS</i>	<i>FIBROMYALGIA</i>	<i>GASTRIC REFLUX</i>
<i>TMJ</i>	<i>NUMBNESS IN HANDS</i>	<i>NUMBNESS IN FEET</i>	<i>CHEST PAIN</i>	
<i>NECK PAIN</i>	<i>MENSTRUAL DISORDER</i>	<i>LOW BACK PAIN</i>	<i>ARM PAIN</i>	<i>OTHER</i> _____
<i>MIGRAINES</i>	<i>HEART DISORDERS</i>	<i>HIP PAIN</i>	<i>ADD/ADHD</i>	_____
<i>ANXIETY</i>	<i>STOMACH DISORDERS</i>	<i>LEG PAINS</i>	_____	_____
<i>CHRONIC SINUS</i>	<i>BLADDER PROBLEMS</i>	<i>KNEE PAIN</i>	_____	_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS _____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

WHEN WAS YOUR LAST AUTO ACCIDENT _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA: _____

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

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. RANDAL HERRING, D.C. AND/OR DR. CAROLINE HERRING MYERS, D.C. AND ANY AND ALL HERRING CHIROPRACTIC CLINIC 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 THE 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 HERRING CHIROPRACTIC CLINIC.

(DATE)

(WITNESS SIGNATURE)

(GUARDIAN SIGNATURE)

(GUARDIAN'S RELATIONSHIP TO MINOR / CHILD)

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 YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS \$15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

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 DISCOVER 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.

PRINT YOUR NAME HERE

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 DISCOVER CHIROPRACTIC.

SIGNATURE

DATE

DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE DO NOT WRITE BELOW THIS LINE

☐ Lat Cervical CM Kvp Time MAS ☐ 10-11 ☐ 78 ☐ 1/24 12.5 ☐ 12-13 ☐ ☐ 1/20 15 ☐ 14-15 ☐ 1/15 20 ☐ 16-17 ☐ 1/10 30 ☐ 2/15 40 MA 300 Size 8x10	☐ Flex/Ext CM Kvp Time MAS ☐ 14-15 ☐ 70 ☐ 1/10 20 ☐ 16-17 ☐ ☐ 2/15 30 ☐ 18-19 ☐ 3/20 40 ☐ 20-21 ☐ 2/10 50 ☐ 22-23 MA 300 Size 8x10	☐ Lower Cervical CM Kvp Time MAS ☐ 14-15 ☐ 70 ☐ 1/10 20 ☐ 16-17 ☐ ☐ 2/15 30 ☐ 18-19 ☐ 3/20 40 ☐ 20-21 ☐ 2/10 50 ☐ 22-23 MA 300 Size 8x10	☐ Lateral Thoracic CM Kvp Time MAS ☐ 22-23 ☐ 80 ☐ 1/15 20 ☐ 24-25 ☐ ☐ 1/10 30 ☐ 26-27 ☐ 2/15 40 ☐ 28-29 ☐ 2/10 50 ☐ 30-31 ☐ 1/4 75 ☐ 32-33 ☐ 3/10 90 ☐ 34-35 ☐ 2/5 120 ☐ 36-37 ☐ 1/2 150 MA 300 Size 14x17	☐ A-P Thoracic CM Kvp Time MAS ☐ 16-17 ☐ 75 ☐ 1/20 17 ☐ 18-19 ☐ ☐ 1/15 22 ☐ 20-21 ☐ 1/10 30 ☐ 22-23 ☐ 2/15 40 ☐ 24-25 ☐ 2/10 50 ☐ 26-27 ☐ 1/4 75 ☐ 28-29 ☐ 3/10 90 ☐ 30-31 ☐ 2/5 120 MA 300 Size 14x17
☐ APOM CM Kvp Time MAS ☐ 14-15 ☐ 70 ☐ 1/10 20 ☐ 16-17 ☐ ☐ 2/15 30 ☐ 18-19 ☐ 3/20 40 ☐ 20-21 ☐ 2/10 50 ☐ 22-23 MA 300 Size 8x10	Other View _____ CM _____ Kvp _____ MAS _____ MA _____ Size _____			
		☐ Lateral Lumbar CM Kvp Time MAS ☐ 26-27 ☐ 88 ☐ 2/10 30 ☐ 28-29 ☐ 90 ☐ 1/4 40 ☐ 30-31 ☐ 92 ☐ 3/10 50 ☐ 32-33 ☐ 94 ☐ 2/5 70 ☐ 34-35 ☐ 96 ☐ 1/2 90	☐ A-P Lumbar CM Kvp Time MAS ☐ 20-21 ☐ 76 ☐ 1/15 40 ☐ 22-23 ☐ 78 ☐ 1/10 50 ☐ 24-25 ☐ 80 ☐ 2/15 75 ☐ 26-27 ☐ ☐ 2/10 90 ☐ 28-29 ☐ 1/4 120	

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home _____ **Cell** _____ **Work** _____

SOCIAL SECURITY NUMBER: _____ **MARITAL STATUS:** _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ **Phone #:** _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured _____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured _____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)**- includes one or 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 done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. \$40-\$60.
- **X-rays**- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care. \$40 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Randal Herring, D.C. or Caroline Herring Myer's, D.C. 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) _____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A.** Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
- B.** Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C.** The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day to doctors of chiropractic in the United States alone.
- D.** A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E.** Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F.** Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G.** We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, 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 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 disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

(Signature)

(Date)

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE

PRACTICE MEMBER'S SIGNATURE

DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

SIGNATURE OF PRACTICE MEMBER OR GUARDIAN

DATE

RELATIONSHIP TO MINOR/CHILD

WITNESS SIGNATURE (OFFICE STAFF)

DATE

HERRING CHIROPRACTIC CLINIC

315 FRIENDSHIP ROAD * P.O. DRAWER 780250 * TALLASSEE, AL 36078

PHONE: (334) 283-6838

FAX: (334) 283-6839

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as an agent or patient, that in consideration of the services to be rendered to the patient, he/she/individually obligates himself/herself to pay the amount charged by Herring Chiropractic Clinic in accordance with the regular rates and terms of payment to the clinic. It is also agreed that in case of default of payment and if this account is placed in the hands of a collector or an attorney for collection, all collection fees, reasonable attorney's fees, costs and all other expenses shall be paid by the undersigned. All parties hereon, whether maker or endorser, each for himself waives notice of dishonor, demand and protest and consents to any extension of time the holder may grant. * If settlement of your insurance case is not reached within (6) months of your release from active care, the patient will be responsible for all unpaid health care bills from this office.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

(Responsible Party Signature)

(Date)

EXPRESS PRIOR CONSENT TO CONTACT PATIENT BY CELL PHONE

You agree, in order for us to service your account or to collect monies you may owe, Herring Chiropractic Clinic and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Herring Chiropractic Clinic, its employees and/or agents may contact me/us described as above.

(Responsible Party Signature)

(Date)

HERRING CHIROPRACTIC CLINIC

315 FRIENDSHIP ROAD * P.O. DRAWER 780250 * TALLASSEE, AL 36078

PHONE: (334) 283-6838

FAX: (334) 283-6839

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Herring Chiropractic Clinic (the practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment and health care operations.

I have reviewed the PRIVACY POLICY of this practice prior to signing this consent. The PRIVACY POLICY may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restriction to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following addresses/phone number/fax number/e-mail addresses:

The practice may communicate confidential information about me to the following individual(s):

(Patient Signature)

(Date)



CUPPING CONSENT TO TREATMENT

I understand and acknowledge that cupping is performed by suction at certain points on the body in an attempt to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware and acknowledge that certain adverse side effects may result, including, but not limited to: local bruising, redness, tenderness, and/ or possible aggravation of symptoms existing prior to cupping treatment.

I understand that I am free to stop cupping treatment at any time.

I understand that cupping does commonly leave marks on the skin that vary in pattern and color (from light to dark purple) and usually last 3 days to 2 weeks, and sometimes longer.

(Signature)

(Date)

(Print Name)



PHOTO/ TESTIMONIAL RELEASE CONSENT

I hereby authorize Herring Chiropractic Clinic and those acting pursuant to its authority to use any recordings including, but not limited to, voice recordings, photographs, videos or any digital entity obtained its office. I acknowledge that my digital recordings will be released to the public via social media/public relations related to Herring Chiropractic Clinic in efforts for promotional, advertising, educational and lawful purposes.

Right to Revoke: You have the right to revoke this Release at any time by providing a written notice of your revocation and submitting it to us. Please understand that revocation of this Release before receiving your revocation will not affect any action Herring Chiropractic Clinic or staff took in reliance on this Release before receiving your revocation.

(Signature)

(Date)

(Print Name)

IF PATIENT IS A MINOR

(Parent Signature)

(Date)

(Child's Name)

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION
FOR THEIR REVIEW.

DATE

PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					