Chiro Idaho Chiropractic
David Meltzer, D.C.
3137 S. Meridian Rd., Suite 110
Meridian, ID 83642
Tel: (208) 807-1609

Today's Date: _____

Legal First Name:	Middle Initial:	Last Name:
Preferred Name / Nickname (if different than legal first name):		
Street:		Apartment/Unit#:
City:	State:	Zip:
Occupation:		Employer:
Birthdate:	Gender:	Email:
Home Phone:	Cell Phone:	Work Phone:
Last 4 of Social Security #:	Marital Status (circle) Single Married Divorced Widowed Other	
Emergency Contact:	Relationship:	Phone Number:

How did you hear about this office?			
Have you seen a chiropractor before? Yes No		If so, when was your last visit?	
List your surgeries here:			
Put an "X" next to all that apply to you			
	High blood pressure		Currently pregnant If so, # of weeks:
	Stroke If so, give date(s):		Abnormal weight gain or loss
	Corticosteroid use (cortisone, prednisone, etc.)		Visual disturbances
	Taking birth control pills		Epilepsy / seizures
	Dizziness / fainting		Nausea / vomiting
	Other health problems:		Osteoporosis

Do you smoke? (circle one)	Never	Former smoker	Current/Every day smoker	Current/Sometimes smoker
Height:	Weight:	Last blood pressure (if known):		

See reverse – Double sided form

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Chiropractors are required to advise patients that there are risks associated with such treatment. You should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The possibilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted). I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care, as well as to the care of my children.

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. **Uses and Disclosures** Your protected health information is accessed and used for healthcare-related purposes only. Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization. Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations. **Certain Circumstances** Your protected health information can be disclosed without your written authorization in certain limited circumstances, medical emergencies; in situations required by law; individuals involved in your care; when requested by public health agency; or when requested by a law enforcement agency. For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time. **Patient Rights** You have the right to request in writing to inspect and/or receive a copy of your health information. * You have the right to request an alternate means or location to receive communications regarding your health information. * You have the right to request in writing to amend, correct, or delete any recorded health information within our possession. * You have the right to request in writing to restrict some of the uses and disclosures of your health information. *You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. * *Conditions and limitations may apply; obtain additional information from the office.*

Changes To This Notice: We reserve the right to change privacy practices and the condition of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted, and a copy will be sent to you.

Professional Services & Office Policies

Please arrive before your appointment times. If you haven't arrived by your appointment time, the appointment may be canceled and payment for the planned service(s) is expected within 7 days. No grace period for late arrivals.

No cell phone use in the office. Please always turn ringers and alarms off before entering office.

Refunds and returned checks: Returned checks will result in an additional $25 charge, also not covered by insurance or any other 3rd party. A 5% processing fee, based upon the initial charge price, will be deducted in the event of a refund request for all credit card payments.

Missed appointments: You must give 24 hours notice to cancel or reschedule an appointment without charge. Missed appointment fees are not covered by insurance companies or any other 3rd party.

Consent and Release: I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

By my signature below, I understand and agree to both the Informed Consent to Chiropractic Treatment, Notice of Privacy Practices, and Professional Services & Office Policies as outlined above.

X _____ _____ _____

Patient Signature (or parent/guardian) | Printed Name | Date

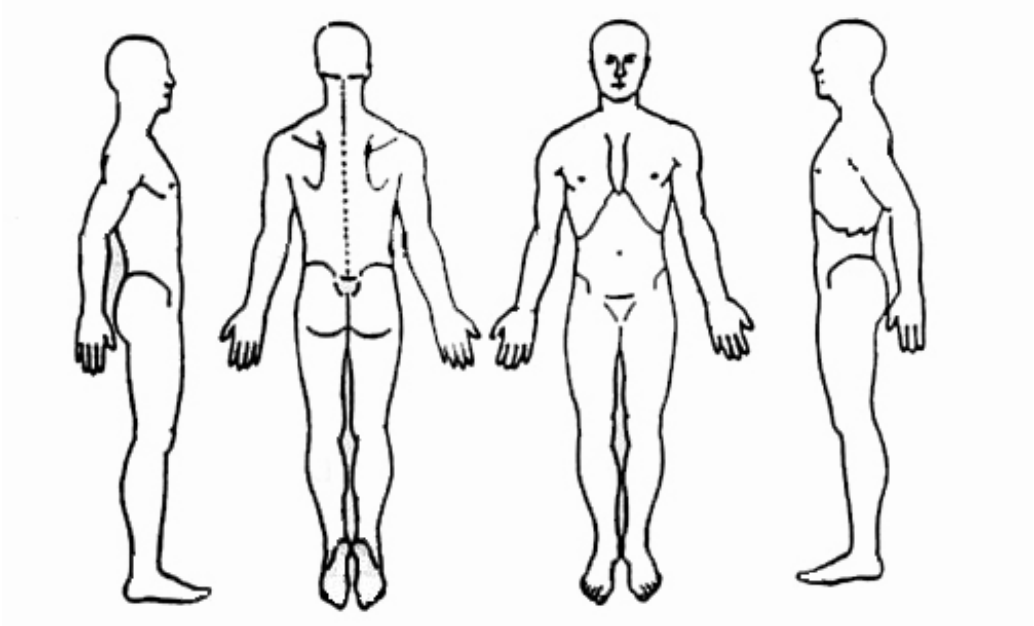
Today's Date: _____

Name:	Birthdate:

	Rate your pain	Describe your pain							What percent of your day do you feel the pain?			
	1 to 10 10 = worst	Ache	Burn	Dull	Sharp	Stiff	Throb	Other	0-25%	26-50%	51-75%	76-100%
Headache												
Neck												
Upper back												
Mid back												
Low back												
Shoulder												
Elbow												
Wrist/Hand												
Hip												
Knee												
Ankle/Foot												

Date problem began?
What seemed to be the initial cause?
What makes it feel better?
What makes it feel worse?
Are you seeing, or have you seen, anyone else for the reason(s) you are here today? Y / N If so, who?
Have you had any of the following imaging for the complaints that brought you here? X-ray MRI CT Scan Other_____
Results of above-mentioned imaging?

Please indicate on the pictures where you have symptoms:



See reverse – Double sided form

Acknowledgement of Rates and Policies

Self-Pay Rates
-Multi-session discount packages are good for 1 year from the date of purchase, or from the date of the initial session, whichever comes first.
-Prices are subject to change without notice.
-Prices are discounted for self-paying patients. These are not the rates billed to an insurance company.
-Anything submitted to a 3rd party payer, like an insurance company, will be billed at a higher rate.

Refund Policy
-When calculating a refund amount, the single session rate will be deducted for each used session.
-Missed appointments, for any reason, will always be deducted in the event of a refund request regardless of the reason for the appointment being missed.
-Refund requests more than 14 days after payment, or after the initial session, whichever came first, will be issued as an office credit only.
-a 5% fee will be deducted in the event of a refund request for any/all credit card purchases.

Canceling, rescheduling, missed appointments, and late arrivals
-Please arrive to the lobby at least 5 minutes before your scheduled appointment time.
-If an appointment is canceled or rescheduled with less than 24 hours' notice, or missed entirely, the full payment for the session will be due immediately. This means the session(s) will be deducted/lost from any multi-session discount package(s).

Self-Pay (non-insurance) Rates

Adjustments

1	$50
5	$225 ($45 avg)
10	$400 ($40 avg)
15	$525 ($35 avg)
20	$600 ($30 avg)

Deep Tissue Laser Therapy
(therapy not covered by insurance)

1	$50
5	$225 ($45 avg)
10	$400 ($40 avg)
15	$525 ($35 avg)
20	$600 ($30 avg)

Spinal Decompression
(therapy not covered by insurance)

1	$100
5	$450 ($90 avg)
10	$800 ($80 avg)
15	$1,050 ($70 avg)
20	$1,200 ($60 avg)

X _____ _____ _____
Patient Signature (or parent/guardian) Printed Name Date