WELCOME TO BROAD STREET CHIROPRACTIC

We thank you for choosing **Broad Street Chiropractic** for your health care needs. We offer state of the art chiropractic care with many other complimentary therapies.

It is important that we know how you heard about our office. Please take a moment and indicate how you heard about our office by putting a check mark in the appropriate box. If more than one choice applies please put a check mark by all that apply. Thank you.

☐ **Referred by**: Please indicate who you were referred by.

☐ ***Existing Patient***: Please write their full name so we may thank them for referring you. _____

☐ ***Doctor, Chiropractor or Health Care Practitioner***: Please write their full name so we may thank them for referring you. _____

☐ ***Attorney***: Please write their full name so we may thank them for referring you. _____

☐ **Managed Care Plan**: Broad Street Chiropractic, or it's doctors, are listed on your managed care plan.

☐ **Yellow Pages**: Please indicate which phone book you were using:

☐ *Durham Verizon*; ☐ *Durham/Chapel Hill Talking Phone Book*, ☐ *Bellsouth-The Real Yellow Pages*

☐ **Internet**: Please indicate which website you were using:

☐ *Google*, ☐ *Verizon Superpages*, ☐ *Yahoo!*, ☐ *City Search*, or ☐ other _____

☐ **Sign**: You saw our sign on the front of the building.

☐ **Publication**: Please write which publication you saw our ad in:

_____

☐ **Other**: Please write how you heard of us if it was not listed above:

_____

Your signature _____ **& Date** _____

CHIROPRACTIC TREATMENT AND ITS RISKS

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing and possibly X-rays. Once your condition has been diagnosed, usually the primary method of treatment is spinal manipulation, also know as spinal adjustment. An adjustment is a quick, precise movement of the spine over a very short distance. Adjustments are usually performed by hand but may be performed by hand guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, deep muscle/ligament massage, cervical or lumbar traction, intersegmental traction (rollerbed), hot and cold packs, dry water massage (hydrobed), exercise/stretches, applied kinesiology, acupressure, acupuncture and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term soreness. More serious side effects can include bone fractures (due to advanced osteoporosis or bone pathology), muscle strain or ligament sprain (inflammation of soft tissue including muscle, tendon, ligament ,disc) , injury to nerves or spinal cord and joint dislocation. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million.

As for chiropractic therapies other than spinal manipulation, the risks are also very slight but can include skin irritation or burns from hot / cold therapy or ultrasound. Occasionally acupuncture may cause mild bruising. Care needs to be taken to insert needles shallow in areas that could be potentially injured to deeper needling. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:
Self administered, over-the-counter analgesics;
Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
Surgery;
Remaining untreated.

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Not receiving chiropractic care and remaining untreated carries its own risk and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

Unusual Risks

If your pre-treatment examination reveals any health issues that would make some forms of chiropractic treatment inadvisable or contra-indicated , Dr. Washington will explain the risks to you and answer any questions you may have.

Patient initials:_____

CONSENT TO CHIROPRACTIC TREATMENT

Dear patient,

Recent guidelines by the North Carolina Board of Chiropractic Examiners require your chiropractic physician to formally explain the treatment being recommended , to inform you of the unusual risks associated with treatment, to explain other treatment options and to answer any questions you may have regarding treatment. You may have been given reading material pertaining to these topics, but your doctor will also discuss them with you in person. Please do not sign this form until you are satisfied that you have received sufficient information to enable you to give your informed consent to treatment.

Note: if the patient is a minor or legally incompetent adult, consent should be given by the patient's parent or legal guardian.

The recommended chiropractic treatment plan has been explained to me, along with any associated risk with chiropractic treatment and other treatment options. I have discussed this with Dr. Washington and my questions have been answered to my satisfaction. No guarantees have been made to me regarding treatment outcomes. I have weighed the risks involved and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to chiropractic treatment.

[If the patient is a competent adult, complete this section.]

Patient name (please print):_____

Patient signature:_____

[If the patient is a minor or legally incompetent adult, complete this section.]

Patient name (please print):_____
Patient age:_____ Date of birth:_____

Person authorized to sign for patient (please print):_____

Relationship to patient: _____

Signature of authorized person:_____ Date :_____

BROAD STREET CHIROPRACTIC

Broad Street Chiropractic is required by law and in compliance with HIPAA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

We may disclose health care information to other healthcare professionals within our practice for the purpose of treatment and healthcare. It is our policy to provide another healthcare provider for your treatment during our absence.

We may disclose your health information to your insurance company for the purpose of payment. As a courtesy, we will submit an itemized statement to your insurance company for the purpose of payment for services rendered. These itemized statements include diagnosis, date of injury or condition, codes describing services rendered and charges.

Health information for patients treated under Worker's Compensation may be disclosed as necessary to comply with State Worker's Compensation Laws.

We may disclose health information to another healthcare provided in response to your referral to or from our office.

We may contact you by mail to provide appointment reminders or information about treatment, alternate treatment or other health benefits, birthday cards, holiday cards, periodic announcements and services that may be of interest to you.

In emergencies, we may disclose your health information to notify or assist in notifying a family member or other individual responsible for your care.

As required by law, we may release health information to public health authorities for purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding, law enforcement official, complying with a court order or subpoena or other law enforcement purposes.

As a courtesy, we may call your home or leave a message, stating your next appointment date and time or missed appointments. No personal health information will be disclosed.

You have the right to request restrictions on certain uses and disclosures of your health information. If you have such a request, please notify Broad Street Chiropractic immediately with the restrictions.

You have the right to inspect and receive a copy of your health information. Further, you have a right to request that Broad Street Chiropractic amend your health information but they are not required to agree to amend it. If your request is denied, you will be given an explanation of denial reasons and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your health information made by Broad Street Chiropractic.

Broad Street Chiropractic is required by law to maintain the privacy of your health information. If you have any questions regarding this notice, you may contact the Privacy Officer by calling (919) 286-9430. If you need to make an appointment with the Privacy Officer you may do so by telephone or in person. If you are not satisfied with the way your complaint is handled, you may request the address to file a formal complaint.

We must disclose your health information to DHHS as necessary for them to determine our compliance with HIPAA standards.

Broad Street Chiropractic retains the rights to add, remove or alter this agreement as deemed necessary. Any such changes will be posted in the physical premises of Broad Street Chiropractic and shall be retroactively effective to the date of original signature.

I have read the Privacy Notice and understand my rights contained in the notice.

I provide Broad Street Chiropractic with my authorization and consent to use my protected Health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (printed)

_____ _____
Patient's Signature Date

_____ _____
Authorized Office Signature Date

I authorize release of any medical information or other information necessary to process any claim.

_____ _____
Patient/Authorized Person Date

Further, I authorize payment of medical benefits for services rendered be made payable to Edward H. Washington, Jr. DC / Broad Street Chiropractic.

_____ _____
Patient/Authorized Person Date

WRITE LEGIBLY

POLICY AND PATIENT DATA

WRITE LEGIBLY

1. **PAYMENT** is due at the time of service, unless other arrangements have been made.
2. An **INSURANCE CONTRACT** is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current.
3. Patients involved in **LITIGATION** (lawsuits) are, as others, responsibile for their services here at the clinic.
4. We reserve the right to **BILL FOR MISSED APPOINTMENTS.**
5. Personal cleanliness is requested due to the close interpersonal nature of this work.
6. **SMOKING IS PROHIBITED.**

PATIENT NAME			HOME PHONE	WORK PHONE	
STREET ADDRESS			CITY	STATE	ZIP
PREVIOUS ADDRESS		CITY	STATE ZIP		
BIRTHDATE	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #	HEIGHT	WEIGHT
OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS		
SPOUSE'S NAME		SPOUSE'S BIRTHDATE	SPOUSE'S SOCIAL SECURITY #	SPOUSE'S WORK PHONE	
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER'S ADDRESS		
IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE NOTIFY?			RELATIONSHIP TO PATIENT	DAYTIME PHONE	

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

PATIENT SIGNATURE:	DATE:	WITNESS SIGNATURE:

IF PATIENT IS A MINOR: Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

GUARDIAN SIGNATURE:	DATE:	WITNESS SIGNATURE:

PLEASE ALLOW OUR OFFICE TO PHOTOCOPY ANY INSURANCE CARD(S) YOU LIST BELOW FOR OUR RECORDS.

INSURANCE #1 (PRIMARY)

PRIMARY INSURANCE COMPANY		NAME OF INSURED	EMPLOYER
I.D. NUMBER		RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS		CITY	STATE ZIP

INSURANCE #2 (SECONDARY)

SECONDARY INSURANCE COMPANY		NAME OF INSURED	EMPLOYER
I.D. NUMBER		RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS		CITY	STATE ZIP

INSURANCE #3 (THIRD)

THIRD INSURANCE COMPANY (If any)		NAME OF INSURED	EMPLOYER
I.D. NUMBER		RELATIONSHIP TO PATIENT (If other than self)	PHONE
BILLING ADDRESS		CITY	STATE ZIP

FORM 10 REV 5/92 ©Copyright 1992 Michael F. Whitton DC PC

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

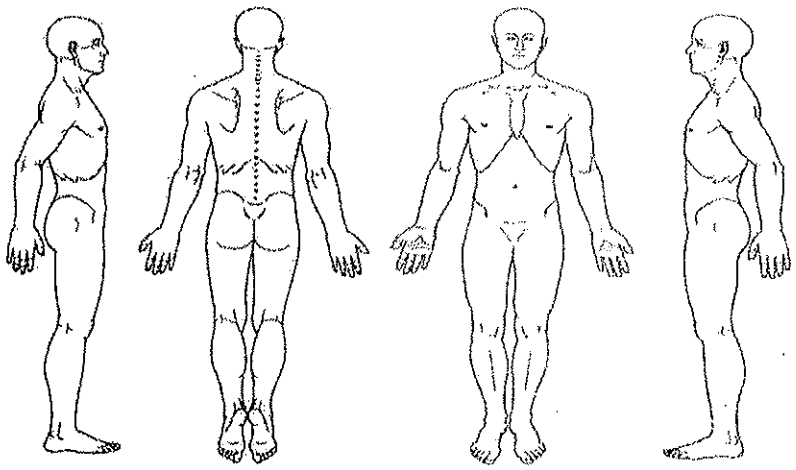
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer			
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____