

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential.
We comply with all federal privacy standards. Please print clearly.



ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Whom may we thank for referring you?

☐ No ☐ Yes When? _____

If so, whom?

Your Last Name

Gender

☐ Male ☐ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

☐ Yes ☐ No

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

First Name

Middle Name (or Initial)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

Insured's Employer

Address

State/Province

ZIP/Postal Code

Employer's Phone

1. The symptom(s) that have prompted me to seek care today include: _____

Patient Name _____

2. And the results of : ☐ An accident or injury
☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem
☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms?)
_____/_____/_____

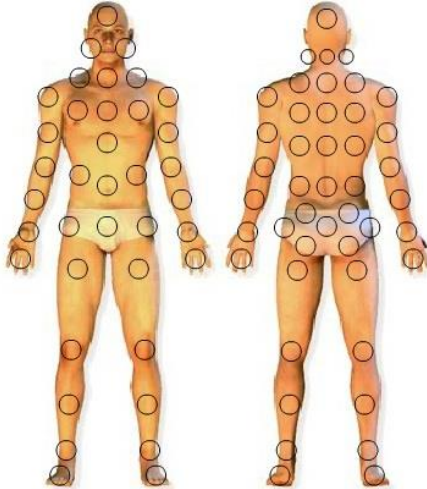
4. Intensity (How extreme are your current symptoms?)
0 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (How often do you feel it?)
☐ Constantly (76-100%)
☐ Frequently (51-75%)
☐ Occasionally (26-50%)
☐ Intermittently (0-25%)

6. Quality of Symptoms (What does it feel like?)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramps
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other _____

7. Location (Where does it hurt?)
Mark the area(s) on the illustration.



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc?)
What tends to worsen the problem?

What tends to lessen the problem?

10. Prior Interventions (What have you done to relieve the symptoms?)

- ☐ Prescription Medication ☐ Surgery ☐ Ice
- ☐ Over-the-counter drugs ☐ Acupuncture ☐ Heat
- ☐ Homeopathic remedies ☐ Chiropractic
- ☐ Physical Therapy ☐ Massage
- ☐ Other _____

11. Have you traveled internationally in the last 6 months? ☐ Yes ☐ No If yes, where? _____

12. What else should the doctor know about your current condition? _____

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire your body. Please mark the box beside any conditions that you **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis	<input type="checkbox"/>	<input type="checkbox"/> Neck pain	<input type="checkbox"/>	<input type="checkbox"/> Back Problems	<input type="checkbox"/>	<input type="checkbox"/> Hip disorders
<input type="checkbox"/>	<input type="checkbox"/> Knee injuries	<input type="checkbox"/>	<input type="checkbox"/> Foot/ ankle pain	<input type="checkbox"/>	<input type="checkbox"/> Shoulder Problems	<input type="checkbox"/>	<input type="checkbox"/> Elbow/ wrist pain	<input type="checkbox"/>	<input type="checkbox"/> TMJ Issues	<input type="checkbox"/>	<input type="checkbox"/> Poor posture
<input type="checkbox"/> NONE										Initials _____	

b. Neurological

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Headache	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Pins & needles
<input type="checkbox"/> NONE								<input type="checkbox"/>	<input type="checkbox"/> Numbness
Initials _____									

c. Cardiovascular

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Poor circulation	<input type="checkbox"/>	<input type="checkbox"/> Angina
<input type="checkbox"/> NONE									
Initials _____									

d. Respiratory

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Apnea	<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> Hay fever	<input type="checkbox"/>	<input type="checkbox"/> Emphysema
<input type="checkbox"/> NONE								<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
Initials _____									

e. Digestive

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Anorexia/ Bulimia	<input type="checkbox"/>	<input type="checkbox"/> Food sensitivities	<input type="checkbox"/>	<input type="checkbox"/> Heartburn	<input type="checkbox"/>	<input type="checkbox"/> Constipation
<input type="checkbox"/> NONE								<input type="checkbox"/>	<input type="checkbox"/> Diarrhea
Initials _____									

f. Sensory

Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>	Had <input type="checkbox"/>	Have <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Blurred vision	<input type="checkbox"/>	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/> Chronic ear infection	<input type="checkbox"/>	<input type="checkbox"/> Hearing loss	<input type="checkbox"/>	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> NONE								<input type="checkbox"/>	<input type="checkbox"/> Loss of taste
Initials _____									

Doctor's Initials _____

g. Integumentary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
<input type="checkbox"/>	<input type="checkbox"/> Skin cancer	<input type="checkbox"/>	<input type="checkbox"/> Psoriasis	<input type="checkbox"/>	<input type="checkbox"/> Eczema	<input type="checkbox"/>	<input type="checkbox"/> Acne	<input type="checkbox"/>	<input type="checkbox"/> Hair loss	<input type="checkbox"/>	<input type="checkbox"/> Rash
<input type="checkbox"/> NONE										Initials _____	

h. Endocrine

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
<input type="checkbox"/>	<input type="checkbox"/> Thyroid issues	<input type="checkbox"/>	<input type="checkbox"/> Immune disorder	<input type="checkbox"/>	<input type="checkbox"/> Frequent urination	<input type="checkbox"/>	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/> Swollen glands	<input type="checkbox"/>	<input type="checkbox"/> Low energy
<input type="checkbox"/> NONE										Initials _____	

i. Genitourinary

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
<input type="checkbox"/>	<input type="checkbox"/> Kidney stones	<input type="checkbox"/>	<input type="checkbox"/> Infertility	<input type="checkbox"/>	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/> Prostate issues	<input type="checkbox"/>	<input type="checkbox"/> Bedwetting	<input type="checkbox"/>	<input type="checkbox"/> PMS symptoms
<input type="checkbox"/> NONE										Initials _____	

j. Constitutional

Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Low libido	<input type="checkbox"/>	<input type="checkbox"/> Sudden weight change	<input type="checkbox"/>	<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Poor appetite	<input type="checkbox"/>	<input type="checkbox"/> Weakness
<input type="checkbox"/> NONE										Initials _____	

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have **Had** in the past of **Have** now.

Had	Have	Had	Have
<input type="checkbox"/>	<input type="checkbox"/> AIDS	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/>	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox		Food: _____
<input type="checkbox"/>	<input type="checkbox"/> Diabetes		Medications: _____
<input type="checkbox"/>	<input type="checkbox"/> Epilepsy		_____
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma		Environmental: _____
<input type="checkbox"/>	<input type="checkbox"/> Goiter	<input type="checkbox"/>	<input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/> Gout	_____	_____
<input type="checkbox"/>	<input type="checkbox"/> Heart disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	_____	_____
<input type="checkbox"/>	<input type="checkbox"/> Malaria		
<input type="checkbox"/>	<input type="checkbox"/> Measles		
<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/>	<input type="checkbox"/> Mumps		
<input type="checkbox"/>	<input type="checkbox"/> Polio		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/>	<input type="checkbox"/> Scarlet Fever		
<input type="checkbox"/>	<input type="checkbox"/> Sexually transmitted disease		
<input type="checkbox"/>	<input type="checkbox"/> Stroke		

17. Injuries

Have your ever....

☐ Had a fractured or broken bone
If so, where _____
when ____/____/____

☐ Had spine or nerve disorder

☐ Been knocked unconscious

☐ Been injured in an accident
If so, when ____/____/____

15. Operations

Surgical interventions which may or may not have included hospitalizations.

	Date
<input type="checkbox"/> Appendix Removal	____/____/____
<input type="checkbox"/> Bypass surgery	____/____/____
<input type="checkbox"/> Cancer	____/____/____
<input type="checkbox"/> Cosmetic Surgery	____/____/____
<input type="checkbox"/> Elective Surgery:	____/____/____

<input type="checkbox"/> Eye Surgery	____/____/____
<input type="checkbox"/> Hysterectomy	____/____/____
<input type="checkbox"/> Pacemaker	____/____/____
<input type="checkbox"/> Spine:	____/____/____

<input type="checkbox"/> Tonsillectomy	____/____/____
<input type="checkbox"/> Vasectomy	____/____/____
<input type="checkbox"/> Other:	____/____/____

☐ Used a crutch or other support

☐ Used neck or back bracing

☐ Received a tattoo

☐ Had a body piercing

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently
<input type="checkbox"/>	<input type="checkbox"/> Acupuncture
<input type="checkbox"/>	<input type="checkbox"/> Antibiotics
<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/>	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/> Chiropractic care
<input type="checkbox"/>	<input type="checkbox"/> Dialysis
<input type="checkbox"/>	<input type="checkbox"/> Herbs
<input type="checkbox"/>	<input type="checkbox"/> Homeopathy
<input type="checkbox"/>	<input type="checkbox"/> Hormone replacement
<input type="checkbox"/>	<input type="checkbox"/> Inhaler
<input type="checkbox"/>	<input type="checkbox"/> Massage therapy
<input type="checkbox"/>	<input type="checkbox"/> Physical therapy
<input type="checkbox"/>	<input type="checkbox"/> Nutritional supplements:
List _____	

☐ Medications (Prescriptions & Over the Counter)

18. Family History

Some health issues are hereditary. Tell the doctor about the health of your **immediate** family members, e.g. mother, father, sister, brother.

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other _____

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell the doctor about your health habits and stress levels.

Alcohol use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Prayer or meditation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coffee use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Job pressure/stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco use	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Financial peace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Exercising	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Vaccinated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain Relievers	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Mercury fillings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Soft drinks	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____	Recreation drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Water intake	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Never	How much? _____			
Hobbies: _____							

21. Activities of Daily Living

How does this condition interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering or bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Love life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking over shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yardwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? ____ Hours

24. What is the **type** and **approximate age** of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

27. What would be the most significant thing you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

Initials I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of late menstrual period (MM/DD/YYYY): _____

Initials I grant permission to be called to confirm or reschedule an appointment and be sent occasional cards, letters, emails or health information to me as an extension of my care of this office.

Initials I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any non-covered services I receive.

Initials To best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity of cause of my health concern.

If patient is a minor child, print child's full name: _____

Signature

Date (MM/DD/YYYY)

Patient Name

Doctor's Initials



ROCKENMACHER

CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Rockenmacher Chiropractic Financial Agreement for Insurance Patients

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care for your condition. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. If you are not familiar with your benefits, we are happy to verify your insurance coverage and go over it with you. **However, it is not a guarantee of benefits and/or payment as your insurance policy is a contract between you and your insurance carrier, not between your insurance carrier and this clinic. We do not keep track of the benefit limitations of your health plan as you may have gone to another practitioner during the year.** Additionally, our doctors are treating you for your condition, not based on your insurance coverage.

In order to verify eligibility and process your claim, we will need a copy of your insurance card and photographic identification. For your convenience, our office will submit bills weekly to your insurance company. It is important that you provide us with current and accurate information, and inform us of any changes to your policy. If policy changes are not reported to us, it may cause claims to either be delayed or denied. If claims are denied for untimely filing due to inaccurate information, the patient will be liable for balances due.

Our office accepts all forms of payments including cash, checks, or major credit cards. Any returned checks will be subject to a \$25 check return/NSF fee. If this account is assigned for collection and/or legal action, all collection fees, attorney fees, court costs and interest will be added to the total amount due.

PPO plans:

Payments for services applied to your deductible, coinsurance or co-pay, and any non-covered services are expected at the time of service. If your insurance company processes the claim differently, a statement will be sent to you at which time the balance will be due. If we are unable to verify your insurance at the time of the initial visit, we will handle your case as if you are a cash patient until we are able to verify eligibility and benefits.

HMO (and select PPO) plans:

Payments for coinsurance, co-pay, and/or any non-covered services are expected at the time of service. Often times, documentation from the patient is required for authorization, but authorization is not guaranteed as treatment is approved based on medical necessity. It is imperative that patients fill out the subjective complaint questionnaires during the course of treatment for continued care to show medical necessity. Should a patient refuse to fill out the required paperwork, payment will be due at the time of service and we will handle your account as a cash patient.

Assignment of Benefits

My signature below constitutes that payments be made directly to Rockenmacher Chiropractic Inc. and authorizes release of medical information necessary to process the claim. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for services rendered that are not covered, authorized or paid by my insurance.

I have read and agree to the above.

Patient's Name

Signature (if minor, guardian must sign)

Date



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CHIROPRACTIC • SPORTS MEDICINE • WELLNESS

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, these are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fracture, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based on the facts then know, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for present condition and or any future conditions for which I seek treatment.

Print name (s) of Doctor Treating This Patient

Jeffrey R. Rockenmacher, D.C.

4152 Katella Ave, Ste #102

Los Alamitos, CA 90720

DO NOT SIGN UNTIL HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient

Date

Signature of Patient

Date

Signature of Patient's Representative

Date

Witness to Patient's Signature

Date

Translated by

Date

Office (562) 598-9609 • Fax (562) 799-1462
4152 KATELLA AVE., SUITE 102 • LOS ALAMITOS, CA 90720



HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

**Notice of Privacy Practices can be obtained at <http://rockenmacherchiropractic.com/new-patient-center/notice-of-privacy-practice.html> or you can request a hard copy from our front desk.*

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

Please **print** name of Patient

Patient **signature** / If Guardian please sign

Please print name of Legal Representative/Guardian

Relationship of Legal Representative / Guardian

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer



ROCKENMACHER
CHIROPRACTIC · SPORTS MEDICINE · WELLNESS

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ **Date of Request:** _____

As required by HIPPA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize Dr. Jeffrey Rockenmacher and his employees to disclose my Patient Health Information to the following person, health care provider or other:

1. **Health Insurance Payer(s):** _____

2. **Family Member(s):** _____

Patient health information authorized to be disclosed:

1. Patient intake forms, chart notes, patient records, Dr's reports, diagnostic studies, diagnosis, prognosis, appointments, balances.

2. Other: _____

For the specific purpose of:

1. Processing of claims, obtaining authorization for treatment, scheduling appointments, collecting balances, and obtaining patient information to facilitate healthcare operations.

2. Other: _____

Effective dates for this authorization: **1/1/2021** through **12/31/2021**. This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect his office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

Signature of Patient or Patient's Authorized Representative

Date