Registration and History

Patient's Name: _____ Today's Date: _____

Keith C. Richard, DC
Dan VanderWeit, DC
Chiropractic Physicians

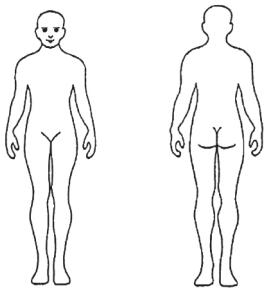
1 Patient Condition

Chief complaint _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ NA

Activities or movements that are painful: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ NA

2 Medical History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐ Yes ☐ No	Chemical Depend./ Alchoholism	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No			Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No	Clotting Disorder	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	Epilepsy/Seizure Dis.	☐ Yes ☐ No	MS	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
						☐ Other _____	

3 Family History

Autoimmune Dis.	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	☐ Other _____
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	
Clotting Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	

Are you pregnant? ☐ Yes ☐ No Who is your Medical Doctor: _____

Do you give us permission to share your records with your primary physician? Y N

Please list all injuries/surgeries you have had: Description Date

Falls: _____ _____

Head Injuries: _____ _____

Broken Bones/Fractures: _____ _____

Dislocations: _____ _____

Surgeries: _____ _____

4 Lifestyle

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Exercise	Work Activity	Habits
☐ None	☐ Sitting	☐ Smoking
☐ Light	☐ Standing	☐ Alcohol
☐ Moderate	☐ Light Labor	☐ Coffee/Caffeine Drinks
☐ Heavy	☐ Heavy Labor	☐ High Stress Level

Height _____
Weight _____
BP _____/_____
Pulse _____

5 Medications | Vitamins/Supplements | Allergies

Medications

1) _____
2) _____
3) _____

Pharmacy Name: _____
Pharmacy Phone: (____) _____

Vitamins/Supplements

1) _____
2) _____
3) _____
4) _____

☐ Daily ☐ Weekly ☐ Occasionally

Allergies

1) _____
2) _____
3) _____
4) _____

How often do they occur? _____

6 Patient Information

Patient Name (Last Name)_____ (First Name) _____ (Middle Initial) _____
Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work
Address: _____ City: _____
State: _____ Zip: _____ Sex ☐ M ☐ F Age: _____ Birth Date: _____
Social Security/DL # _____ ☐ Married ☐ Single ☐ Partnered
Occupation: _____ Patient Employer/School: _____
Address: _____ Phone: _____
In case of emergency, contact: _____ Relationship: _____ Phone: _____
Whom may we thank for referring you? Event you attended? _____

7 Payment/Insurance Information

Who is responsible for this account? _____
☐ Self-Pay Name(s) of responsible parties: _____
Relationship to patient: _____
☐ Government Program Name: _____ ID # _____
☐ Health Insurer Name: _____ ID # _____ Group # _____
Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____
Is this policy associated with an ☐ HSA ☐ FSA ☐ HRA? ☐ Yes ☐ No
Is patient covered by additional/ secondary insurance? ☐ Yes ☐ No
Insurance Co. Name: _____ ID # _____ Group # _____
Subscriber Name: _____ Birth Date: _____ Relationship to Patient: _____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent to treatment by Keith C. Richard, DC, 3) assign to Keith C. Richard, DC any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by Keith C. Richard, DC, authorize their payment directly to Keith C. Richard,DC, and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to Keith C. Richard, DC (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to Keith C. Richard, DC releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of Keith C. Richard, DC's notice of privacy practices.

_____ _____
Printed name of Patient, Parent, Guardian or Personal Representative
Signature of Patient, Parent, Guardian or Personal Representative

Relationship: _____ Date: _____

8 Family Information

Children's Name(s)	Sex	Date(s) of Birth	Children's Name(s)	Sex	Date(s) of Birth
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____

Keith C. Richard, DC
Dan VanderWeit, DC
Chiropractic Physicians

Payment and Assignment of Benefits

In consideration of any services provided by Keith C. Richard, DC in addition to those included in any pre-paid offer, you agree to: 1) be primarily responsible for all charges owed to Keith C. Richard, DC, including attorney fees, court costs, and other expenses of collection, 2) irrevocably assign and transfer to Keith C. Richard, DC, all right, title, and interest to health insurance or reimbursement benefits to which you are entitled forthe purpose of payment of the charges owed to Keith C. Richard, DC and 3) authorize payment of such benefits directly to Keith C. Richard, DC.

If you have health insurance, you acknowledge that our verification of your health insurance benefits is only an estimate of benefits payable to you, if any, and that health insurance benefits may vary due to the coverage the plan sponsor offered or the coverage you purchased, you or the plan sponsor's failure to pay premiums, termination of the plan by the sponsor, your failure to otherwise remain eligible (e.g., not maintaining full-time employment status), error, and other causes. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not covered by health insurance.

If you have a health savings account (HSA), flexible spending account (FSA), or a health reimbursement account (HRA), you must inform us so that we can make appropriate arrangements for payment.

You acknowledge that our verification of health reimbursement benefits is only an estimate of benefits payable to you, if any, and that health reimbursement benefits may also vary. We do not directly bill to any HSA, FSA, or HRA plan, but, depending upon your plan provisions, automatic withdrawals may occur when we submit charges to any primary health insurer. Any refund or reimbursement to an HSA, FSA, or HRA account cannot exceed your out-of-pocket contribution toward any treatment. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not eligible for health reimbursement benefits.

_____ initial

Keith C. Richard, DC
Dan VanderWeit, DC
Chiropractic Physicians

Payment and Assignment of Benefits *(Continued)*

If you are a Medicare, Medicaid, or other government healthcare program participant, you assign, and request that payment of, all benefits be made on your behalf for healthcare services rendered, directly to us. You also authorize any holder of medical or other information about you to release to the Centers of Medicare and Medicaid Services or other applicable government program office and its agents, any information needed for payment of benefits.

_____ initial

Medicare Release

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. You authorize payment or benefits to us on Patient's behalf.

_____ initial

Medical Records Privacy and Consent to Release Information

Keith C. Richard, DC respects your privacy. We comply with the Health Insurance Portability and Accountability Act ("HIPAA"), and we mayrelease your "protected health information," as defined by HIPAA, only as allowed by law, such as:

- For your treatment and care coordination;
- To obtain payment for your healthcare;
- To your family, friends, or others you identify who are involved with your healthcare or your healthcare bills, unless you object; or
- In response to a subpoena, court order, or otherwise in connection with a claim, lawsuit, or proceeding in which you are involved.

We do not sell any of your "protected health information" for marketing or any other purpose. Accordingly, you consent to us releasing your "protected health information" only as allowed by law. You also acknowledge receipt of Chiro One's Notice of Privacy Practices.

_____
(Signature of Patient or Responsible Party; parent, guardian or other representative) (Date)

_____
(Signature of Policy holder) (Relationship) (Date)

_____
(Signature of Witness to signing of consent form) (Date)

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE