CAMPION CHIROPRACTIC CLINIC

• Feel Better • Move Better • Do More

Patient Application

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

Chart Number	Date

1 Patient Contact

First Name	M.I.	Last Name
Preferred to be called:		
Street Address		
City	State	Zip
Home Phone	Cell Phone	
Work Phone	Email	

2 Patient Personal

Age	Date of Birth	Social Security #	Birth Sex ☐ Male ☐ Female

Status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 Emergency Contact

Name	Primary Phone
Relationship	Secondary Phone

4 Employment/Education

Employer Name	Occupation
Current School	Sports/Extra-Curricular Activities

5 Patient Insurance

Insurance
☐ Self-Pay/No Insurance ☐ BCBS ☐ Aetna ☐ Cigna ☐ Humana ☐ Medicare ☐ Personal Injury Protection (PIP) ☐ Other:

Insurance Subscriber ID #	Insurance Group #
PIP Adjuster's Name	PIP Claim #

How did you hear about us? (please check all that apply)

☐ I'm a Former Patient ☐ Insurance List ☐ Other Doctor ☐ Attorney ☐ Massage Therapist ☐ Google ☐ Facebook ☐ Friend/Family ☐ Website ☐ Zoc-Doc
☐ Other:

WOMEN: Are you pregnant? ☐ Yes ☐ No ☐ Unsure

WARNING: *If you are or might be pregnant and do not notify the doctor, this could be hazardous to your health and the health of your baby, and this office will not be held responsible*.

I understand and agree to the following:

- A history, consultation, examination, and x-rays conducted for diagnostic and informational purposes.
- My case may not be accepted for treatment at this clinic.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.
- I request the service mentioned above.

Patient/Guardian Signature

Date

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6 Patient Information

First Name	M.I.	Last Name

7 Health Concerns

Are you here because you were injured while working? ☐ Yes ☐ No **Are you here because of an auto accident**? ☐ Yes ☐ No

What services interest you? (Please check all that apply)

☐ Adjustments/Alignments	☐ Treatment for Pain	☐ Education/Answering Questions
☐ Balance Training	☐ Prevention/Maintenance Care	☐ Range of Motion, Mobility, Flexibility
☐ Strength and Stamina	☐ Shockwave Therapy (ESWT)	☐ Spinal Decompression
☐ Cold Laser	☐ Graston and Myo-Fascial Release	☐ Other:

Where are you experiencing the most pain or concern?

How long have you been experiencing this concern?

How does this concern feel? ☐ Dull Ache ☐ Sharp ☐ Numb/Tingling ☐ Tense/Tight ☐ Weak ☐ Burning ☐ Other:

How often do you experience this concern? ☐ All the time. ☐ Frequently. ☐ Sometimes. ☐ Rarely.

Using the scale below, rate how your concern affects your life. (mark only one box below)

0	1	2	3	4	5	6	7	8	9	10
No Problem	Barely There	Minor, Annoying	Noticeable, Distracting	Moderate, Very Distracting	Strong, Hard to Ignore	Can't Ignore, Disturbs Activity	Severe Dominates Senses	Intense, Limits Physical Activity	Excruciating, Unable to Speak	Unspeakable, Bedridden, Delirious

If you have missed work because of your concern, when was your last day of work?

What do you believe is causing your concern?

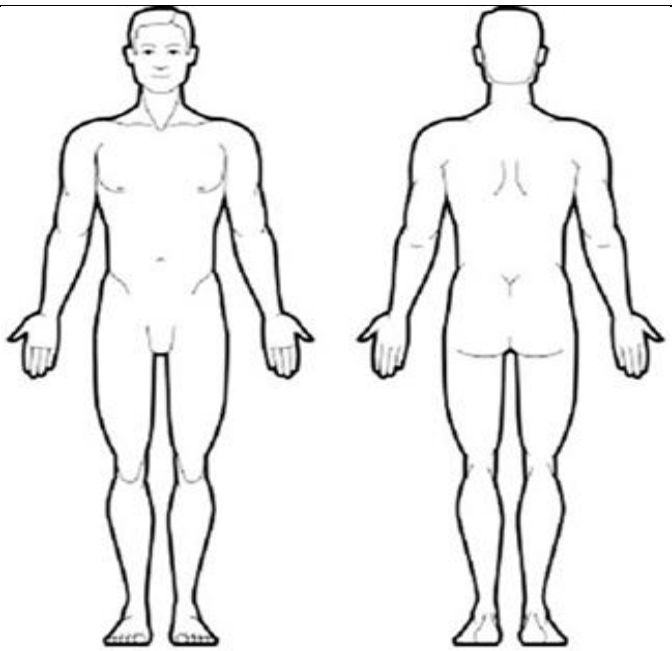
List other health concerns (2-5) on the following lines:

2 _____ 4 _____

3 _____ 5 _____

Do you have any other health condition other than what brings you here? (ex. Diabetes, High Blood Pressure, etc.?)

Please use the body drawings to the right to explain your concerns. Feel free to draw, write, or anything to help you express what the issue is.



Signature:

8 Financial Policy

Sehorn Chiropractic PLLC dba Campion Chiropractic and Sports Injury Clinic, and staff welcome you to our office. We are here to serve your healthcare needs and appreciate the opportunity to do so. We have sincerely endeavored to keep your health care costs in this office as reasonable as possible so that you may feel financially, as well as physically, comfortable while pursuing the ultimate health that chiropractic provides. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope you will take responsibility for your financial obligation to our practice/office. The following are general policies we have established for our patients which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment agreements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. **INSURANCE**- As a courtesy to our patients, we will verify your insurance at or before your first visit to our office. We will file claims on all visits and procedures performed in our office. Fees are based on the contracted insurance company's guidelines. Depending on your insurance carrier, these fees may vary. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Sehorn Chiropractic PLLC (that is, the insurance company will pay Sehorn Chiropractic PLLC directly). You are responsible for payments of all deductibles, co-insurance, co-pays, and non-covered services. Please remember, insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and payment to your doctor rests with you.

2. **REFERRALS** – We gladly accept referrals from other doctor's offices. You are required to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see the doctor. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits, so you should be careful to monitor the dates and visits. If your insurance company requires a valid referral for evaluation/treatment and you do not have one, you will be rescheduled for another day.

3. **NO INSURANCE** – Patients who do not have insurance are expected to pay for all services rendered on the day of treatment. We understand that individual situations may make it difficult to meet these financial expectations and we are happy to discuss payment arrangements as needed based on treatment recommendations.

4. **RETURNED CHECKS** – Your account will be charged a $30 fee for each returned check. In addition, you will be asked to bring cash/money order to our office to cover the returned check amount and fees incurred. CCC 2023.02.25

5. **PAST DUE ACCOUNTS** – Patients who have not tried to make payment arrangements or have not expressed an interest in meeting their financial obligations to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, plus pay for any fees incurred from the agency. You will be expected to pay for any future services in advance, before being seen by our doctors.

6. **NON-COVERED SERVICES** – Medicare and certain insurance companies will only pay for services which they determine to be "reasonable and necessary". If Medicare or another insurance company determines that your visit with our doctors/clinic is not "reasonable and necessary", then they will deny payment for that service. Sometimes insurance companies will not cover an office visit/examination prior to a procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need visits with the doctor/clinic beforehand.

Our doctor/clinic recommends a consultation and/or spinal screening prior to any treatments or procedures in order to evaluate the patient's history and general health. The patient will then be informed about any examinations, physical therapy, spinal decompression, low level laser therapy, Graston, therapeutic exercises, manual therapy, and other diagnostic tests that may be needed in order to diagnose your condition and start treatment. We are required to inform you, and we are doing so now, that your insurance company may not cover the consultation, office visit, examination, spinal manipulation, extracorporeal shockwave therapy, spinal decompression, manual therapy, low level laser therapy, Graston, and/or other physical therapy modalities and that you will be responsible for payment. If for any reason, after a thorough consultation, examination, and x-rays (if necessary), your problem is NOT a chiropractic case or that we CANNOT help you, we will advise you of such and refer you to someone we think can help you.

7. **24-HOUR CANCELLATION POLICY** – If you no-call, no-show or cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a fee of $40. To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. Exceptions to this policy may include emergencies or at the approval of the doctor.

Patient Statement: I have been informed of Sehorn Chiropractic PLLC's financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for my initial office visit, examination, or other procedures and treatments for the reasons stated above. If Medicare of my insurance company denies payment, I agree to be personally and fully responsible for payment.

Patient/Guardian Signature: _____ Date:_____

Witness Signature: _____ Date:_____

9 Informed Consent

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give you consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic xrays. The chiropractic treatment may be performed by a licensed Doctor of Chiropractic working at this clinic or office or serving as a backup for the Doctors at this clinic.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but no limited to:

- Broken Bones • Dislocations • Sprains/Strains • Burns or Frostbite (physical therapy)
- Worsening/Aggravation of Spinal Conditions • Increased symptoms or pain • Bruising (Graston, MFR, Shockwave)
- No improvement of symptoms or pain • Other: _____

(In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. The reported complication of artery dissection by chiropractic cervical adjustment is rare and has been reported in approximately 1 out of a million treatments. To put that risk into perspective, complications from aspirin are 1 in ten thousand, and birth control 1 in five thousand.)

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment. The doctor cannot be responsible for any pre-existing medically diagnosed conditions.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan, and I intend this consent to cover the entire course of treatment for my current condition(s).

Signature of Patient or Responsible Party: _____

Printed Name: _____

Today's Date: _____

To be completed by doctor or staff:

Witness to patient's signature: _____ Date: _____

Translated by: _____ Date: _____

10 Notice of Privacy Rights

Your Protected Health Information (herein "PHI") will be used or disclosed to others for the purposes of your treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Some of these include having your name on a sign-in sheet, posted on a referral board, and used on charts and records that may be seen by others while in this office. We may also use various means of contacting you including phone calls, emails, and mail-outs such as appointment cards, birthday cards, and newsletters. Our office may leave messages on your phone, voice recorder, send emails, or text messages to you that may contain PHI. This office utilizes an open treatment and therapy area where your PHI may be heard or seen by other patients. We also consider this protected PHI.

You must list any restrictions on the release of your PHI below. Sehorn Chiropractic PLLC dba Campion Chiropractic reserves the right to accept or deny those listed below based on our PHI Notice information.

□ No restrictions

□ Restrictions: _____

You should review the Notice of Privacy Practices (herein "Notice") that was received by you (if requested) and posted on the wall in the reception area for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of any health information, including your demographic information, collected from you and created or received by this office.

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

You have the right to revoke this consent, which must be done in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. This office reserves the right to modify the privacy practices outlined in the Notice.

I have reviewed this Consent Form and the Notice (as posted or requested), and give my permission to be examined, treated, and receive any examinations and office procedures that the provider deems necessary. I also allow this office to use and disclose my PHI in accordance with that stipulated above and in the Notice.

Patient/Guardian's Signature: _____ Date: _____

Signed Patient/Guardian's Name (printed): _____

Guardian's Relationship: _____

Witness Signature: _____ Date: _____