

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Birth Date: _____ Age: _____

Address: _____

Sex: Male / Female

City _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License #: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Names & Ages of Children: _____

Referred To This Office By: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Relationship: _____

Who is Responsible for your bill, you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID #: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Have You Had Previous Chiropractic Care? _____

Insured Person's Social Security #: _____

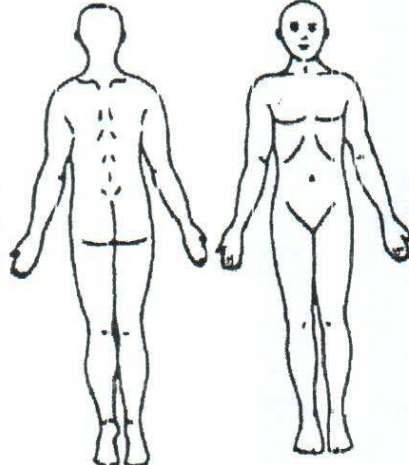
Name of Previous Chiropractor: _____

Amount of Time Under Care of a Chiropractor? _____

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto Related Work Related Other No Injury

Explain: _____

Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filed an injury report with your employer? Yes No

Claim #: _____

TERMS OF ACCEPTANCE CHIROPRACTIC INFORMED CONSENT

For Patient: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office and what is available today thanks to progress in spinal health care.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to

permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.

Corrective care: Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.

Wellness care: Spinal neglect is so common. It has become an epidemic in our society—despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal of Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, _____, have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature

Date

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian

Date

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature

Date

Lighthouse Spine and Rehab Chiropractic Centre

Policies

1. All 1st adjustment charges are payable when services are rendered.
2. X-ray film is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Dr. Jeffery LaGrec, D.C. will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Lighthouse Spine and Rehab Chiropractic Centre and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize Lighthouse Spine and Rehab Chiropractic Centre to obtain a credit report if deemed necessary.

Patient Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

In Case of Emergency Notify _____

Relationship _____ Address _____

Phone # _____

Lighthouse Spine and Rehab
Chiropractic Centre
Dr. Jeff LaGree, D.C.
Dr. Jeff Fortes, D.C.
3922 DuPont Square South Suite D
Louisville, KY 40207
Office (502) 899-9540 Fax (502) 899-9541

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Lighthouse Spine and Rehab Chiropractic Centre, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Lighthouse Spine and Rehab Chiropractic Centre.

Authorization To Release Medical Record Information:

Lighthouse Spine and Rehab Chiropractic Centre is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, Organizations, or agencies as may be responsible for payment of services rendered by Lighthouse Spine and Rehab Chiropractic Centre. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Lighthouse Spine and Rehab Chiropractic Centre.

The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____

Signature of Patient or Responsible Party: _____