Date:	<u> </u>

# COMMONWEALTH CHIROPRACTIC CENTER, PSC 1827 Ky Route 321 Prestonsburg, KY 41653 (606) 889-9222

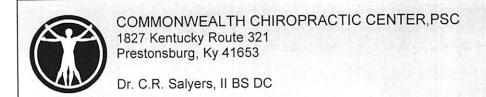
NAME	AGE	_DATE OF BIRTH	//	SEX
HEIGHT'" WEIGHT				
DOMINANT HAND R or L RACE	_ ETHNICI	ΓΥ	LANGUA	GE
SMOKER YES OR NO IF YES, EVERYDAY, SOMED.	AY,OR FORM	MER SMOKER		
E-MAIL ADDRESS		DRIVE	R'S LICENSE	
ADDRESS	CITY	s	TATE	ZIP
PHONECELL PHON	E		S.S.#	
MARITAL STATUS CHILDREN:     NO	[ ] YES HO	W MANY?B	BREASTFEED	ING Y OR N
EMPLOYER/OCCUPATION		PH	IONE	
SPOUSE'S NAMES.	S.#/_	/DA	TE OF BIRTH	I/
EMPLOYER/OCCUPATION		PH	IONE	
IN CASE OF EMERGENCY, CONTACT		PI	HONE	
WHOM MAY WE THANK FOR REFERRING YOU TO	THIS OFFI	CE		
HEALTH INFORMAT	ION (FILL C	OUT ALL THAT AP	PLY)	
MAJOR COMPLAINT			HOW LON	NG
ARE YOUR SYMPTOMS RELATED TO AN ACCIDEN	NT OR INJUR	XY?IF YE	S, EXPLAIN_	
DURING THE ACCIDENT WERE YOU IN THE COUR	DSE OF VOI	D EMPLOVMENT?		
HAVE YOU EXPERIENCED YOUR SYMPTOMS BEF				
HAVE YOU EXPERIENCED TOOK STWII TOWS BEI	OKE THIS A	CCIDENT:	11 125, 271 2	
IF YOUR SYMPTOMS ALREADY EXISTED WERE T	HEY MADE	WORSE BY THIS A	CCIDENT	OR
WERE YOUR SYMPTOMS DORMANT PRIOR TO THIS ACCIDENT				
DOCTORS SEEN FOR THIS CONDITION				
NAME/ADDRESS OF YOUR MEDICAL DOCTOR				
HAVE YOU EVER HAD PREVIOUS CHIROPRACTIC CARE?     NO     YES DOCTOR				
HAVE YOU HAD ANY OF THE FOLLOWING: AUTO ACCIDENTS-SEVERE FALLS-SURGERIES-FRACTURES				
PLEASE EXPLAIN				
<u></u>				

# MEDICAL HISTORY/REVIEW OF SYSTEMS

# HAVE YOU EVER HAD A HISTORY OF OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING (CHECK BELOW) IF YES EXPLAIN

YES	NO	
		EPILEPSY/SEIZURES
	-	
	3	
		HEART ATTACK
		STROKE/TIAHIGH BLOOD PRESSURE
		BLOOD CLOTSHEART MURMUR/VALVE DISEASE
		HEART MURMUR/VALVE DISEASE
		IRREGULAR HEARTBEAT
		CONGESTIVE HEART FAILUREARTIFICIAL JOINTS OR HEART VALVES
		ARTIFICIAL JOINTS OR HEART VALVES
		INTERNAL PACEMAKER OR DEFIBRILLATOR
		BRAIN STIMULATOR
		CANCER (IF SO, WHAT KIND)
		SKIN CANCER/MELANOMA
		BROKEN/IRRITATED SKIN
		MIGRAINE HEADACHES/OTHER HEADACHES
		ANEMIA
		EXCESSIVE SCARRING OR BLEEDING
		VISUAL PROBLEMS/EYE DISEASE
		ARTHRITIS
		GOUT
		DIABETES
		LUNG DISEASE/RESPIRATORY PROBLEMS/TB
		DEPRESSION/MENTAL ILLNESS
		DI COD ED ANGELIGIONIO
		HIM DISEASE AIDS
		THE CONTROL OF THE CO
		ALLERGIES
		HYPOTHYROIDISMOTHER DISEASES
		METALLIC IMPLANTS NEURO STIMULATOR
	A	STENT, SHUNT, PAIN PUMP
		SHRAPNEL
		CLAUSTRAPHOBIC
Have vo	ou recently	had a CT/MRI within the last year? YES NO if yes where?
Are voi	currently	taking Ibuprofen/Motrin? YES OR NO if yes How long, and milligram
		vsical Therapy within the last year? If so, how long and where?

# ANSWER THE FOLLOWING FOR AUTO ACCIDENT OR WORK COMP INJURY ONLY Have you experienced any of the following since your accident or injury: A. Loss of Range of Motion: yes/no a. What body parts: B. Visual Disturbance: yes/no (please explain): How often: C. Dizziness: yes/noD. Anxiety: yes/noE. Depression: yes/no How often: How often: How often: F. Difficulty Sleeping: yes/no MEDICATIONS KNOWN MEDICATION ALLERGIES Family Health History: Associated health problems of relatives: Deaths in immediate family: Age at death Cause of parents or siblings death Social and Occupational History: A. Recreational activities: B. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): Source of the contract of SIGNATURE



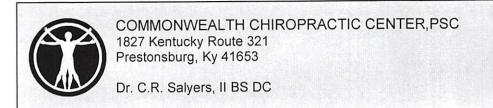
Fax: 606-886-1605

## AUTHORIZATION, ASSIGNMENT, AND RELEASE FORM AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

- 1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
- 2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me of you based in whole or in part upon the charges made for your services.
- 3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company(the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fir and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
- 4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Kentucky.
- 5. I further agree that this Authorization and Assignment is irrevocable an ongoing until all monies owed are paid in full.
- 6. This Authorization for Assignment will be in continual effect until revoked by both parties.

DATE	PATIENT/INSURED SIGNATURE
	RECORDS RELEASE
Salvers II any informatio	, I hereby authorize you to release to <b>Dr. Charles R. "Chip"</b> n including the diagnosis and records of treatment or examination rendered to m od from thru
	PATIENT/INSURED SIGNATURE
DATE	PATIENT/INSURED SIGNATURE
MEDICAT	IONS AUTHORIZATION FOR RELEASE FROM DR. FIRST
any and all prescription in	st Website. I hereby authorize Dr. Charles R. "Chip" Salyers II, to retrieve formation on my behalf to be in compliance with the "Meaningful Use
regulations".	X
DATE	PATIENT/INSURED SIGNATURE



Fax: 606-886-1605

#### INFORMED CONSENT

PATIENT'S NAME	X	

#### Dear Patient:

State law requires us to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

#### ASSOCIATES AND ASSISTANTS

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment.

#### **EXAMINATIONS**

<u>X-ray</u>: Concerning x-ray examination, this office uses direct digital radiography that provides the highest quality of xrays with the least exposure. Please note that on your initial visit and re-exam (which includes new complaint(s) and x-ray videos) you will receive xrays if warranted, unless pregnant. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The only noteworthy inherent risk with taking x-rays, deals with pregnancy. If there is a possibility that you are pregnant, inform this office prior to x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that I have no available statistics to quantify their probability.

#### **TREATMENT**

<u>The Chiropractic Adjustment</u>: I will use my hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

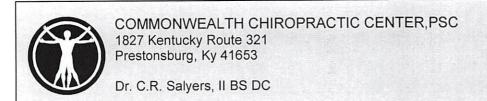
## INHERENT RISKS

<u>Pain</u>: It is common for an adjustment as well as traction, massage therapy, exercise, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone; however it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

<u>Disc Herniation</u>: Occasionally treatment will aggravate or cause a problem if the disc is in a weaken state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

<u>Stroke</u>: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. So rare that you have the same chance of getting hit by lightening; one in a million. In fact, according to the Journal of the Canada Chiropractic Association Vol. 37, No. 2 June, 1993, the risk of a stroke from



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chiropractic is one per every three million upper neck adjustments. Even though the risk of stroke in this office is small, we have implemented procedures, and tests that reduce your risk of stroke even more.

The type of adjustment related to vertebral artery stoke is called the extension-rotation-thrust atlas adjustment. This type of adjustment is not done in this office. Our patients are also given certain tests that warn of certain conditions more susceptible to stroke, thus reducing your risk even more.

<u>Physical Therapy Burns</u>: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that I haven't found any statistics to quantify its probability.

<u>Other Problems</u>: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., than noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advances of treatment.

### NON TREATMENT

Remaining untreated results in adhesions, pain and, reduction in associated joint mobility which. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

### OTHER PROBLEMS

There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery. As with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

I hereby authorize and direct the above named doctor with assistants to provide such additional services as they may deem reasonable and necessary.

I hereby state that I have read or have had read to me this consent form, and all blanks were filled in prior to my signature.

DATE:	_ TIME:	A.M. P.M.
Patient's Printed Name: X		
Patient's Signature: X		
Signature of Guardian:		
Witness' Printed Name:		
Witness' Signature:		

### COMMONWEALTH CHIROPRACTIC CENTER, PSC

1827 Ky Route 321 Prestonsburg, Ky 41653 606-889-9222

## Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

## Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Commonwealth Chiropractic Center, PSC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

## **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy Patient Initials

## Requesting a Restriction on the Use or Disclosure of Your Information

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

## Notice of Treatment in Open or Common Areas

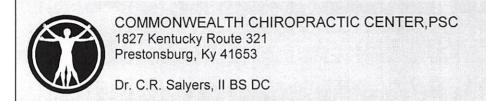
Describe and Notify private areas available upon request

#### Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent 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.

By my signature below I give my permission to use and disclose my health information.

X	
Patient or Legally Authorized Individual Signature	Date
X	
Print Patient's Full Name	Time
Witness Signature	Date



Fax: 606-886-1605

Name	Date
Please initial one of the following:	
I, hereby give Dr. Charles R. "Chip" Salyer Chiropractic Center, consent to give to my spouse or pertaining to me (medical or financial). I also under divorce, it is my responsibility to inform this office of and finances.	other family member any information stand that at some point, if I change my mind, or
I, hereby decline to give Dr. Charles R. "Ch Chiropractic Center, consent to give to my spouse or pertaining to me (medical or financial). I also under divorce, it is my responsibility to inform this office of and finances.	stand that at some point, if I change my mind, or