Bridge Spine & Wellness
Darren C. Campbell, DC

Name_____Date of Birth: ___/___/____ Age:_____

Address_____City_____

State_____Zip_____

Marital Status: ____ Single ____Married ____ Widowed

Name of Spouse (if applicable):_____

E-mail Address:_____

Occupation: _____

Work Phone: _____

CellPhone:_____HomePhone:_____

In order of importance, list the body parts that are bothering you most and please rate that pain on a pain scale from 0-10 (10 being the worst pain)

1._____2._____

3._____4._____

In order of severity, list functions you are unable to perform or have pain performing.

1._____2._____

3._____4._____

Have you had any similar health problems or injuries before? ____ Yes ____ No If yes, explain:

_____

_____

Have you ever received chiropractic care? ___ Yes ___ No If yes, when was your last visit._____

Have you had any surgeries ____Yes_____(If yes please explain)_____

_____Insurance _____Cash Pay *Please give us your insurance card to make a copy.

List the approximate dates of any accidents, operations, or serious injuries (including broken bones) you have had:

_____

_____

_____

Please list your or have us make a copy of your medication list:

_____

HIPAA NOTICE

WE WANT YOU TO KNOW HOW YOUR PATIENT HEALTH INFORMATION (PHI) IS GOING TO BE USED IN THIS OFFICE AND YOUR RIGHTS CONCERNING THOSE RECORDS. BEFORE WE WILL BEGIN ANY HEALTH CARE OPERATIONS, WE MUST REQUIRE YOU TO READ AND SIGN THIS CONSENT FORM STATING THAT YOU UNDERSTAND AND AGREE WITH HOW YOUR RECORDS WILL BE USED. IF YOU WOULD LIKE TO HAVE A MORE DETAILED ACCOUNT OF OUR POLICIES AND PROCEDURES CONCERNING THE PRIVACY OF YOUR PHI, WE ENCOURAGE YOU TO READ THE **HIPAA NOTICE** THAT IS AVAILABLE TO YOU AT THE FRONT DESK BEFORE SIGNING THIS CONSENT.

1. THE PATIENT UNDERSTANDS AGREES TO ALLOW THIS CHIROPRACTIC OFFICE TO USE THEIR PHI FOR THE PURPOSE OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND COORDINATION OF CARE. AS AN EXAMPLE, THE PATIENT AGREES TO ALLOW THIS CHIROPRACTIC OFFICE TO SUBMIT REQUESTED TO THE HEALTH INSURANCE COMPANY OR COMPANIES PROVIDED TO US BY THE PATIENT FOR THE PURPOSE OF PAYMENT. BE ASSURED THAT THIS OFFICE WiLL LIMIT THE RELEASE OF ALL PHI TO THE MINIMUM NEEDED FOR WHAT THE INSURANCE COMPANIES REQUIRE FOR PAYMENT.
2. THE PATIENT HAS THE RIGHT TO EXAMINE AND OBTAIN A COPY OF HIS OR HER OWN HEALTH RECORDS AT ANY TIME AND REQUEST CORRECTIONS. THE PATIENT MAY REQUEST TO KNOW WHAT DISCLOSURES HAVE BEEN MADE AND SUBMIT IN WRITING ANY FURTHER RESTRICTIONS ON THE USE OF THEIR PHI. OUR OFFICE IS NOT OBLIGATED TO AGREE TO THOSE RESTRICTIONS.
3. A PATIENT'S WRITTEN CONSENT NEED ONLY BE OBTAINED ONE TIME FOR ALL SUBSEQUENT CARE GIVEN THE PATIENT IN THIS OFFICE.
4. THE PATIENT MAY PROVIDE A WRITTEN REQUEST TO REVOKE CONSENT AT ANY TIME DURING CARE. THIS WOULD NOT AFFECT THE USE OF THOSE RECORDS FOR THE CARE GIVEN PRIOR TO THE WRITTEN REQUEST TO REVOKE CONSENT BUT WOULD APPLY TO ANY CARE GIVEN AFTER THE REQUEST HAS BEEN PRESENTED.
5. FOR YOUR SECURITY AND RIGHT TO PRIVACY, ALL STAFF HAS BEEN TRAINED IN THE AREA OF PATIENT RECORD PRIVACY AND AN OFFICIAL HAS BEEN DESIGNATED TO ENFORCE THOSE PROCEDURES IN OUR OFFICE. WE HAVE TAKEN ALL PRECAUTIONS THAT ARE KNOWN BY THIS OFFICE TO ASSURE THAT YOUR RECORDS ARE NOT READILY AVAILABLE TO THOSE WHO DO NOT NEED THEM.
6. PATIENTS HAVE THE RIGHT TO FILE A FORMAL COMPLAINT WITH OUR PRIVACY OFFICIAL ABOUT ANY POSSIBLE VIOLATIONS OF THESE POLICIES AND PROCEDURES.
7. IF THE PATIENT REFUSES TO SIGN THIS CONSENT FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, THE CHIROPRACTIC PHYSICIAN HAS THE RIGHT TO REFUSE ANY SERVICE.

I HAVE READ AND UNDERSTAND HOW MY PATIENT HEALTH INFORMATION WILL BE USED AND I AGREE TO THESE POLICIES AND PROCEDURES.

PATIENT SIGNATURE_____

DATE_____

Authorization and Release

I AUTHORIZE PAYMENTS OF INSURANCE BENEFITS TO THE CHIROPRACTOR OR CHIROPRACTOR OFFICE. I AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO COMMUNICATE WITH PERSONAL PHYSICIANS AND OTHER HEALTHCARE PROVIDERS AND PAYERS AND TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF THE CHIROPRACTIC CARE, REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY SCHEDULE OF CARE AS DETERMINED BY MY TREATING DOCTOR, ANY FEES FOR PROFESSIONAL SERVICES WILL BE IMMEDIATELY DUE AND PAYABLE. I UNDERSTAND THAT INTEREST IS CHARGED ON AN OVERDUE ACCOUNT AT THE ANNUAL RATE OF 16%

THE PATIENT UNDERSTANDS AND AGREES TO ALLOW THIS CHIROPRACTIC OFFICE TO USE THEIR PATIENT HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS AND COORDINATION OF CARE. WE WANT YOU TO KNOW HOW YOUR PATIENT HEALTH INFORMATION IS GOING TO BE USED IN THIS OFFICE AND YOUR RIGHTS CONCERNING THOSE RECORDS. IF YOU WOULD LIKE A MORE DETAILED ACCOUNT OF OUR POLICIES CONCERNING THE PRIVACY OF YOUR PATIENT HEALTH INFORMATION, WE ENCOURAGE YOU TO READ THE HIPAA NOTICE THAT IS ATTACHED BEFORE SIGNING THIS CONSENT. IF THERE IS ANYONE YOU **DO NOT** WANT TO RECEIVE YOUR MEDICAL RECORDS, PLEASE INFORM OUR OFFICE STAFF. THANK YOU

PATIENT'S SIGNATURE_____

GUARDIAN'S SIGNATURE_____

TO THIS PATIENT: READ ENTIRE DOCUMENT PRIOR TO SIGNING IT. IT IS IMPORTANT TO UNDERSTAND THE INFORMATION CONTAINED. PLEASE ASK QUESTIONS FOR ANYTHING THAT IS UNCLEAR.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

THE PRIMARY TREATMENT I USE AS A DOCTOR OF CHIROPRACTIC IS SPINAL MANIPULATIVE THERAPY. I WILL USE THAT PROCEDURE TO TREAT YOU. I MAY USE MY HANDS OR A MECHANICAL INSTRUMENT UPON YOUR BODY IN SUCH A WAY AS TO MOVE YOUR JOINTS. THAT MAY CAUSE AN AUDIBLE "POP" OR "CLICK", MUCH AS YOU HAVE EXPERIENCED WHEN YOU CRACK YOUR KNUCKLES. YOU MAY FEEL A SENSE OF MOVEMENT.

ANALYSIS/EXAMINATION/TREATMENT – INITIAL EACH PROCEDURE YOU CONSENT TO

AS A PART OF THE ANALYSIS, EXAMINATION, AND TREATMENT, YOU ARE CONSENTING TO THE FOLLOWING PROCEDURES:

____ SPINAL MANIPULATIVE THERAPY ____ ORTHOPEDIC TESTING ____VITAL SIGNS

____ BASIC NEUROLOGICAL TESTING ____ PALPATION ____EMS

____ RANGE OF MOTION TESTING ____ RADIOGRAPHIC STUDIES ____HOT/COLD THERAPY

____MUSCLE STRENGTH TESTING ____ POSTURAL ANALYSIS ____ ULTRASOUND

____ OTHER (PLEASE EXPLAIN): _____

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC AS WITH ANY HEALTHCARE PROCEDURE, THERE ARE CERTAIN COMPLICATIONS WHICH MAY ARISE DURING CHIROPRACTIC MANIPULATIONS AND THERAPY. THESE COMPLICATIONS INCLUDE BUT ARE NOT LIMITED TO: FRACTURES, DISC INJURIES, DISLOCATIONS, MUSCLE STRAIN, CERVICAL MYELOPATHY, COSTOVERTEBRAL STRAINS AND SEPARATIONS, AND BURNS. 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. SOME PATIENTS WILL FEEL SOME STIFFNESS AND SORENESS FOLLOWING THE FIRST FEW DAYS OF TREATMENT. I WILL MAKE EVERY REASONABLE EFFORT DURING THE EXAMINATION TO SCREEN FOR CONTRAINDICATIONS TO CARE; HOWEVER, IF YOU HAVE A CONDITION THAT WOULD OTHERWISE NOT COME TO MY ATTENTION, IT IS YOUR RESPONSIBILITY TO INFORM ME.

THE PROBABILITY OF THOSE RISKS OCCURRING

FRACTURES ARE A RARE OCCURRENCES GENERALLY RESULTING FROM SOME UNDERLYING WEAKNESS OF THE BONE, WHICH I CHECK FOR DURING THE TAKING OF YOUR HISTORY AND DURING EXAMINATION AND X-RAY. STROKE HAS BEEN THE SUBJECT OF TREMENDOUS DISAGREEMENT. THIS INCIDENCES OF STROKE ARE EXCEEDINGLY RARE AND ARE ESTIMATED TO OCCUR ONE AND ONE IN FIVE MILLION CERVICAL ADJUSTMENTS. THE OTHER COMPLICATIONS ARE GENERALLY DESCRIBED AS RARE.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

TREATMENT OPTIONS FOR YOUR CONDITION MAY INCLUDE:

- SELF-ADMINISTRATED, OVER-THE-COUNTER ANALGESICS AND REST
- MEDICAL CARE AND PRESCRIPTION DRUGS SUCH AS ANTI-INFLAMMATORY OR PAIN KILLERS
- HOSPITALIZATION
- SURGERY

IF YOU CHOSE TO USE ONE OF THE ABOVE TREATMENT OPTIONS, YOU SHOULD BE AWARE THAT THERE ARE RISKS AND BENEFITS OF SUCH OPTIONS AND YOU MAY WISH TO DISCUSS THESE WITH YOUR PRIMARY CARE PHYSICIAN.

THE RISKS AND DANGER ATTENDANT TO REMAINING UNTREATED

REMAINING UNTREATED MAY ALLOW THE FORMATION OF ADHESIONS AND REDUCE MOBILITY WHICH MAY CAUSE PAIN REACTION FURTHER REDUCING MOBILITY. OVER TIME THIS MAY COMPLICATE TREATMENT MAKING IT MORE DIFFICULT AND LESS EFFECTIVE THE LONGER IT IS POSTPONED.

DO NOT SIGN UNTIL YOU HAVE READ & UNDERSTAND THE INFORMATION. CIRCLE THE APPROPRIATE OPTION BELOW.

I HAVE READ or I HAVE READ TO ME

THE ABOVE EXPLANATION OF THE CHIROPRACTIC ADJUSTMENT AND RELATED TREATMENT. I HAVE DISCUSSED IT WITH **DR. DARREN CAMPBELL** AND HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION. BY SIGNING BELOW, I STATE THAT I HAVE WEIGHED THE RISKS INVOLVED AND HAVE DECIDED THAT IT IS IN MY BEST INTEREST TO UNDERGO THE TREATMENT RECOMMENDED. HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE CONSENT TO TREATMENT.

PRINT PATIENT'S NAME: _____

SIGNATURE: _____ **DATE:**_____

PARENT/GUARDIAN SIGNATURE (if minor):_____ **DATE:**_____