Patient Information

_____ _____ _____ _____

Last name First name Date of Birth Age Gender

_____ _____

Occupation Hobbies (golf, walking, cooking, etc.)

_____

Home Address

_____ _____ _____

City State Zip Code

(_____) _____ - _____ _____

Phone Number Email address

___ *Opt-out of receiving text message notifications. Messaging rates may apply*

_____ _____ (_____) _____ - _____

Emergency Contact Name Relationship Phone Number

Are you Medicare eligible? (Y/ N)

Have you ever been to a Chiropractor? (Y/ N)

I AGREE that Savage Chiropractic, PC / Savage.Clinic, its affiliates, vendors, and agents can email me at the email address above or call or text message me at the phone number provided, even if I am on a federal or state do not call registry for any purpose, including marketing. Message and data rates may apply. I understand that consent to receive calls or texts is not required to receive this service.

_____ _____

Patient or Legal Guardian Signature Date

Notice of Privacy Practices & HIPAA

THIS IS NOTICE OF PRIVACY AND AUTHORIZES SAVAGE CHIROPRACTIC, PC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

- I give permission to Savage Chiropractic, PC / Savage.Clinic to use my name, address, phone numbers, and clinical records to contact me with, health-related e-mail messages, information about treatment alternatives, or other health-related information as well as any advertisements, birthday cards, holiday-related cards, newsletters, or patient of the week/month postings.
- I give permission to Savage Chiropractic, PC/ Savage.Clinic to treat me in an open room where other patients are also being treated. I am aware that other people in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

We understand that medical information about you or your health is personal and we are committed to protecting this information. When you receive Chiropractic treatment from us, a record of the treatment you received is made. Typically, the record contains your treatment plan, your history and physical, any X-ray/ MRI/CT images and test results you provide to us, and a billing record. This record serves as the basis for planning your treatment and a tool for assessing ways to improve the care rendered.

We are required by law to:

1. Maintain the privacy and security of your medical information
2. Provide you with notice of our legal duties and privacy practices with respect to the information we collect and maintain about you
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We may use and disclose medical information about you for purposes related to your treatment, payment, health care operations, contacting you, appointment reminders, as required by law, health oversight activities, lawsuits, and disputes, law enforcement with a court order/subpoena and electronic disclosure.

Your rights regarding your medical information:

1. Right to inspect and copy
2. Right to amend
3. Right to an accounting of disclosures
4. Right to request restrictions
5. Right to revoke an authorization
6. Right to receive a copy of this document

We reserve the right to change our practices and to make new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request a copy be provided to you by contacting us.

I understand and have been provided with a notice of information practices that provide me with a more complete description of information uses and disclosures. I understand my rights and privileges. By signing the following I am giving SAVAGE CHIROPRACTIC permission to use and disclose my protected health information in accordance with the directives listed above.

_____ _____

Signature of Patient/Legal Guardian Date

Chiropractic Consent

PATIENT NAME:_____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors 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 *(please initial each procedure you are consenting to.)*

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy ___ palpation ___ vital signs
___ range of motion testing ___ orthopedic testing ___ basic neurological testing
___ muscle strength testing ___ EMS ___ ultrasound
___ hot/cold therapy ___ postural analysis testing ___ radiographic studies
___ other (please explain) _____

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation 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. The Doctor 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 the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other 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 medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Informed Consent

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: Your chiropractic doctor may use his/her hands or a device to manipulate the area being treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment may also include activity advice, exercise, hot or cold packs, electric stimulation, or other types of therapy. Your chiropractic doctor will recommend the treatment that is most appropriate for your condition.

Possible risks: Chiropractic treatment is safe and the majority of patients experience improvement. Approximately 30% of patients experience slight pain in the treated area, possibly due to a minor strain of muscle, tendon, or ligament. When this occurs, the pain is brief and self-limiting over the next few days. Temporary minor pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritations, burns, or electrical shocks may occur with thermal or electrical therapy but are rare. Some soft tissue treatments may produce local discomfort, reddening of the skin, and superficial tissue bruising/soreness during and post-treatment.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many factors can adversely affect one's health, including a previous injury, medications, osteoporosis, cancer, and other illnesses, diseases, or conditions. When complicating factors are present, chiropractic treatment may be associated with serious adverse events such as fracture, dislocation, or aggravation of existing injuries. Your chiropractic doctor is aware that symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care and will assess for symptoms and signs of stroke if appropriate. The incidence of stroke associated with neck adjustments is exceedingly rare (1 in 1 to 5 million) and while current research does not refute a causal relationship, it strongly suggests associated strokes are already in progress at the start of the visit rather than the result of the care provided.

Please inform your chiropractic doctor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical conditions, including osteoporosis, heart disease, numbness, cancer, stroke, fracture, or previous severe injury.

Other options for treatment include: do nothing and live with it, over-the-counter medications, physical therapy, medical care, injections, surgery, and many others. Most treatments that have potential benefits also have potential risks. You are encouraged to ask questions regarding possible risks of chiropractic treatment and may use the space below for this purpose.

*****Do not sign below until asked by your doctor.*****

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractic doctor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. In addition, I have told my chiropractic doctor about my medical history regarding the above-specified complicating factors, if any.

_____	Dr. Hansalak Savage, DC
Patient's Name	Clinician's Name
_____	_____
Patient Signature (Guardian if Minor)	Clinician Signature
Date: _____	Date: _____

Photography & Videography Release

Savage Chiropractic, PC

We are proud of our patients and the progress they make while under our care! There is nothing we enjoy more than celebrating our patient's success along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here - and most importantly, getting results!

I _____(please print) grant permission to "Savage Chiropractic, PC" and its agents and employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me for the purpose of publication, education, promotions, advertising and illustration in any manner or in any medium. I hereby release "Savage Chiropractic, PC" for all claims and liability relating to said images and/or video. Furthermore, I waive my right to any compensation.

_____ _____

Print Name Signature

_____

Date

_____ _____

Phone number Email

Terms and Conditions

Please initial the following:

_____ Patient agrees to timely notify us of any changes in patient's personal information, including mailing address, insurance policy, telephone number, and credit/debit card information. We reserve the right to suspend services while such information is pending from the patient.

_____ I understand that Savage Chiropractic, PC is not responsible for lost or stolen articles or goods while I am present at their facility.

_____ I agree to notify Savage Chiropractic of cancellation of my appointment at least 12 hours prior to appointment time. I understand that if unable to do so, I may be subjected up to a $500.00 no-show fee at the clinic's discretion.

_____ In the event of any dispute, controversy, or claim arising out of or related to these Terms and Conditions, the agreement, your treatment, or the services received at Savage Chiropractic, PC, the patient understands and agrees that patient and Savage Chiropractic, PC shall first attempt promptly and in good faith, to resolve any such dispute in mediation. Failure by the patient to deliver a formal mediation notice prior to the inception of a legal claim or lawsuit shall constitute prima facie evidence and basis for Savage Chiropractic, PC seeking a motion to dismiss the lawsuit. If the patient is unable to resolve such dispute by mediation within a reasonable time (not to exceed 60 days), YOU AS THE PATIENT AGREE THAT THE DISPUTE SHALL, UNLESS OTHERWISE MUTUALLY AGREED BY THE PARTIES FOR ANY PARTICULAR DISPUTE, BE RESOLVED EXCLUSIVELY BY BINDING ARBITRATION BEFORE THE AMERICAN ARBITRATION ASSOCIATION, PURSUANT TO THE THEN-CURRENT CONSUMER ARBITRATION RULES. ANY ARBITRATION COMMENCED BETWEEN YOU AND SAVAGE CHIROPRACTIC, PC MUST BE AGREED TO ARBITRATION. YOU ARE WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE IN COURT, THE RIGHT TO HAVE THE DISPUTE DECIDED BY A JUDGE OR JURY, AND THE RIGHT TO BRING, OR BE PART OF, A CLASS ACTION CASE.

_____ Payment is expected at the time of service unless other arrangements have been made with the receptionist prior to treatment.

_____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will verify your benefits and coverage and will try to have this information ready for you prior to your first visit with our office. *Please be aware, this verification is an estimate of benefit and not a guarantee of payment.*

_____ As a service to you, we will bill your health insurance for services rendered. Some insurance companies may mail the check directly to you. And checks issued to you must be forwarded to Savage Chiropractic, PC endorsed on the back, and written on the check "Pay to the Order of Savage Chiropractic, PC". If you chose to write a personal check in the amount of the insurance payment, please included a copy of the explanation of benefits so we may apply your payment to the proper date of service. This payment is due within 15 days of receipt along with any and all EOB's.

By initialing and signing this contract you are agreeing to the terms and conditions written above.

_____ _____

Signature of Patient or Legal Guardian Date

Chiropractic Consent

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Savage Chiropractic, PC to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child (Name): _____

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Savage Chiropractic, PC, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Patient or Guardian (if a minor)

Initial Visit Patient Intake Information

Name: _____ DOB:_____ Gender: _____

Main Compliant (why are you here?)_____

How did this begin: _____

When did your symptoms begin? _____ Has this happened before? (Y / N)

What makes your problem better?_____

What makes your problem worse? _____

Describe your pain / symptoms: _____

_____

_____

Does your pain radiate (into the arms / leg, etc.)?_____

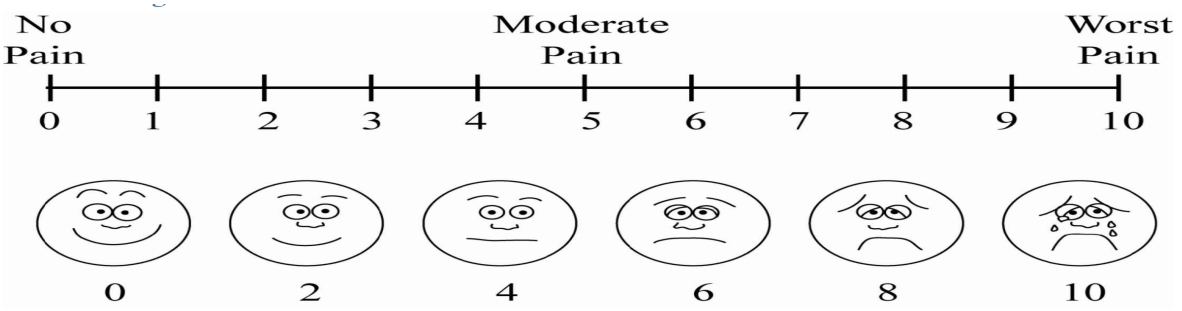
Since the problem began, has it Improved _____ Worsened _____ No change _____

The problem bothers me:

Occasionally (0-25% of the time) _____ Intermittently (25-50% of the time) _____

Frequently (50-75% of the time) _____ Constantly (75-100% of the time) _____

Rate your pain as of today:



When do you notice your pain the most?

Morning _____ Afternoon _____ As the day progresses _____ Night ____

Other (_____)

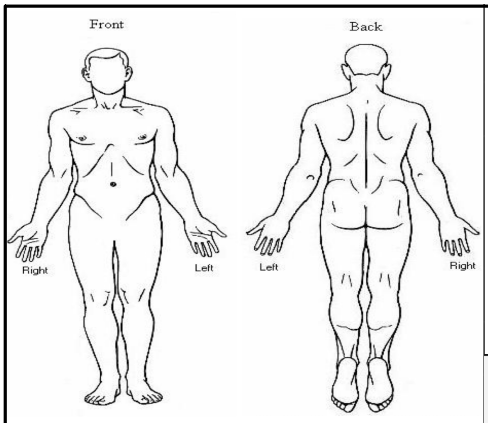
Do you have any other associated symptoms? _____

Previous Treatment(s): _____

_____

_____

On the diagram below, please indicate where you are experiencing pain or other symptoms.



Quality	Achy Sharp Dull Numb Stiff Burning Electrical Other

Please check ✓ all of the following that apply:

___ Past History of Cancer	___ Current or recent urinary tract, respiratory tract or other infection
___ Unexplained weight loss	___ Immunosuppression medication and/or condition (HIV infection)
___ Recent fever of chills	___ History of significant trauma such as motor vehicle accident or fall
___ Pain worse at night	___ Minor trauma or strenuous lifting injury in person over 50 years old
___ Pain not relieved by rest	___ Osteoporosis (Weak bones)
___ Changing position does *not* modify pain	___ Over 70 years old
___ Over 50 years of age	___ History of prolonged use of corticosteroids
___ Under 20 years of age with sever, disabling pain	___ Loss of bladder control (urinary retention or overflow incontinence)
___ No significant improvement after more than 1 month of conservative care	___ Loss of bowel control
___ Spinal pain more than 4 consecutive weeks	___ Numbness in groin area
___ Anticoagulant therapy *(Heparin, Warfarin, Coumadin)*	___ Global or progressive weakness in the legs (do legs give out?)
___ Abdominal pain	
___ History of high blood pressure, smoking, family obesity	
___ Intravenous drug use	

Past Medical History (please include dates):

Surgery: _____

Hospitalization: _____

Illness: _____

Injury / Trauma: _____

Allergies: _____

Medication(s): _____

_____

Vitamins/Supplements/Herbs:_____

_____

Family History (Parents/ Grandparents / Siblings):

___ Cancer	___ Stroke	___ Lung disease	___ Migraine headaches
___ Heart problems	___ Aneurysm	___ Osteoporosis	___ Alcohol dependence
___ Hight blood pressure	___ Diabetes	___ Rheumatoid Arthritis	___ Seizures

Social History:

Do you use tobacco? (Y / N / Quit) _____ Pack(s) per day for _____ Year(s) Smoking:____

Recreational, Intravenous, or Performance Enhancing Drugs? (Y / N)

If yes what type of drugs?_____

Alcohol: Never___ Rarely___ Socially___ Daily; If yes: Drink(s)/day _____

Are you sexually active? (Y / N) If yes: Do you practice safe sex? (Y / N)

Describe your lifestyle: Sedentary___ Moderate___ Vigorous___

Do you exercise? (Y / N) What activity(ies):_____

_____

How often?_____

How many hours of sleep do you get per night? _____hours/night

Rate the quality of sleep: Excellent____ Good____ Average____ Fair____ Poor____

How would you rate your stress? Very High____ High____ Medium____ Low____ Very Low___

What contributes to your stress? _____

Do your like your work situation? Yes ___ No___

If no please explain why: _____

How would you rate your diet? Excellent___ Good___ Average___ Fair___ Poor___

How would you rate your sugar intake? Excellent___ Good___ Average___ Fair___ Poor___

Explain:_____

Caffeine intake: Coffee___ Tea___ Energy Drinks___ Soda ; _____ cup(s)/day

How would you describe your overall health? Excellent__ Good__ Average__ Fair__ Poor__

Review of system (Check ✓ all that apply)

Constitutional	Nose	Cardio/Respiratory	Breasts/Genitals
___ Fever	___ Pain	___ Heart murmur	___ Mass/Lump
___ Chills	___ Discharge	___ Chest pain	___ Pain
___ Night sweats	___ Bleeding	___ Palpitations	___ Discharge
___ Weakness		___ Difficulty breathing	___ self-exam
___ Fatigue	Mouth/Throat	___ Coughing	
___ Unexplained weight loss	___ Difficulty swallowing	___ Wheezing	Psychological
	___ Pain	___ Blue hands/feet	___ Anxiety
Eyes	___ Sores	___ Swollen extremities	___ Depression
___ Difficulty seeing	___ Pain in taste		___ Mood swings
___ Pain		Musculoskeletal pain / Paranesthesia	___ Memory loss
___ Discharge	GI/GU	___ Neck	Skin
___ Blurred/double vision	___ Change in appetite	___ Upper extremity	___ Rash
	___ Abdominal pain	___ Upper back	___ Itching
Ears	___ Vomiting	___ Lower extremity	___ Discoloration
___ Difficulty hearing	___ Diarrhea	___ Lower back	___ Hair change
___ Ringing (Tinnitus)	___ Constipation		___ Nail change
___ Pain	___ Painful Urination	Neurological	
___Discharge	___ Frequent urination	___ Headaches	
	___ Incontinence	___ Dizziness	
		___ Fainting	
		___ Convulsions	