Ehlich Chiropractic Clinic, Inc
5895 Chesnee Hwy
Chesnee, SC 29323
Phone: 864-461-2313 Fax: 864-461-2312

PLEASE PRINT

Name:_____ SS#_____ DOB: ___/___/___ Age: _____

Address: _____City: _____ State: _____ Zip Code: _____

Phone: _____ Sex: __ Marital Status: S M W Spouse Name: _____

Patient Occupation: _____ Employer: _____Work Phone: _____

Address: _____ DL# _____ Home Phone: _____

Children: ___ Emergency Contact Name: _____ Relation: _____ Phone: _____

Have you been to a Chiropractor before? Y N If so, when: ___ / ___ / ___ How did you hear about us?_____

List your chief's complaints in order of severity:

Complaint	How long?	Probably the cause?	List other Dr's consulted for these conditions:
1._____			1. _____
2._____			2. _____
3._____			3. _____

Is this due to an injury: Y N All first visit charges are payable when services are rendered:

Informed Consent to Chiropractic Treatment:

The nature of chiropractic treatment: The doctor will use his / her hands or a mechanical device in order to move your **joints**. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultrasound may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include bone fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in one twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". Other treatment options which could be considered may include the following: **Over-the-counter analgesics:** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases: **Medical care**, typically anti-inflammatory drugs, tranquillizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. **Surgery** in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. **Risks of remaining untreated**: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility; and induce chronic pain cycles. It is quite probable that delay in treatment will complicate the condition and make future rehabilitation more difficult. **Unusual risks**: I have had the following unusual risks of case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment**. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.**

Sign & Date_____

Name: _____

EHLICH CHIROPRACTIC CLINIC, INC.

Chief Complaint Sheet

Please mark health concerns you have experienced.

Rate the degree of pain, if any,

<u>On a scale of 1 – 10 (1 = mild pain; 10 = worst imaginable)</u> Please circle area(s) of your unwanted health problems

Please state how long you have experienced the symptoms:

	# 1 – 10	How long:		# 1 – 10	How long:
Headaches	____	____	Diarrhea	____	____
Neck Pain	____	____	Stomach	____	____
Shoulder Pain	____	____	Ulcer	____	____
Arm Pain	____	____	Hernia	____	____
Elbow Pain	____	____	High Blood Pressure	____	____
Hand Pain	____	____	Low Blood Pressure	____	____
Mid Back Pain	____	____	Kidney Problems	____	____
Low Back Pain	____	____	Prostate Problems	____	____
Hip Pain	____	____	Hemorrhoids	____	____
Leg Pain	____	____	Chest Pain	____	____
Knee Pain	____	____	Abnormal Heartbeat	____	____
Ankle Pain	____	____	Diabetes	____	____
Swelling Joints	____	____	Cancer	____	____
Heel Spurs	____	____	Difficulty Breathing	____	____
Feet Pain	____	____	Asthma	____	____
Weakness	____	____	Thyroid Problems	____	____
Dizziness	____	____	Lump in Throat	____	____
Numbness	____	____	Throat Constriction	____	____
Fainting	____	____	Menstrual Problems	____	____
Sinus	____	____	Hot Flashes	____	____
Indigestion	____	____	Excessive Perspiration	___	____
Allergies	____	____	Clammy Hands	____	____
Gall Bladder	____	____	Sexual Difficulty	____	____
Heartburn	____	____	Nervousness	____	____
Poor Appetite	____	____	Other Not Listed	____	____
Trouble Appetite	____	____	Constipation	____	____
Poor Memory	____	____	Gas	____	____

Female patients: Are you pregnant? Yes, No, or unsure? (Please circle one)

Do any of these symptoms cause you to be?

Moody ____ Irritable ____ Do any of these symptoms effect your work in?

Productivity Y N Attitude Y N

Decision Making Y N Hours Worked Y N

Do any of these symptoms affect your life?

Hinder your normal exercise habits: Y N Cause lack of patience: Y N

Interferes with hobbies/social activities: Y N Hinder your household duties: Y N

Mental Symptoms (Please circle any of the following fears you may have):

Crowds Cancer Stroke Heights Being Alone Heart Trouble

PATIENT NAME: _____ DATE: _____

1. CAUSE OF CONDITION _____
2. CONDITION OCCURRED ON _____
3. FREQUENCY OF SYMPTOMS CONSTANT COME-AND-GO NONE
4. SYMPTOMS ARE MOST EXTREME IN THE MORNING AFTERNOON NIGHT ALL DAY
5. SYMPTOMS ARE _____
6. SYMPTOMS HAVE PERSISTED FOR DAYS WEEKS MONTHS YEARS
7. PRESCRIBED MEDICATIONS _____

PLEASE CIRCLE WHICH ACTIVITIES MAKE YOUR SYMPTOMS WORSE!

BENDING
BOWEL MOVEMENT
BUZZING IN EARS
COLD WEATHER
COUGHING
DRIVING
LIFTING
LYING DOWN
MASSAGE
MUSCLE JERKING
PICKING UP OBJECTS
REACHING
SITTING
SNEEZING
STANDING
STRETCHING
TURNING HEAD
WALKING
WORK

PLEASE CIRCLE WHICH ACTIVITIES MAKE YOUR SYMPTOMS BETTER!

BENDING
BOWEL MOVEMENT
BUZZING IN EARS
COLD WEATHER
COUGHING
DRIVING
LIFTING
LYING DOWN
MASSAGE
MUSCLE JERKING
PICKING UP OBJECTS
REACHING
SITTING
SNEEZING
STANDING
STRETCHING
TURNING HEAD
WALKING
WORK

DO YOU HAVE ANY OF THESE ADDITIONAL SYMPTOMS?

BLURRED VISION
BUZZING IN EARS
CONSTIPATION
HEAD SEEMS TOO HEAVY
LOSS OF BALANCE
MUSCLE JERKING
PINS AND NEEDLES IN ARMS
TESTICLE PAIN

TRAUMA SHEET

Name _____ Date_____ DOB____/____/_____

The vast majority of our patients have literally dozens of impacts and injuries that can cause subluxations, I am going to try and discover a few of yours today.

When was your most recent automobile accident?

_____

_____

_____

_____

Most people have had a slip or fall, when was your most recent:

_____

_____

When was your most recent injury lifting?

_____

_____

What sporting or recreational activities do you or have you participated in in the past?

_____

What injury sticks out in your mind that we have not gone over yet?

_____

_____

Are you under any stress? ____ Physical ____ Mental ____ Work ____ Personal?

What accident has occurred that we have not gone over yet?

_____

These sound important, thank you for helping us better understand your accident history. Many times, after you leave here, you will remember other incidents. If you do, please let us know so that it may be written down for the doctor to consider.

Depending on the severity of a subluxation, the nerve pressure can be ____ constant or ____ comes and goes. Is it worse in the ____ morning or at ____ night?

Subluxation can cause irritation to different nerve fibers. Would you describe this?

____ Sharp ____ Dull ____ Achy ____ Throbbing, Other _____

Many times, a vertebral subluxation can cause neurological problems are you experiencing any

____ Tingling ____ Numbness ____ Burning:

Subluxations can cause weakness through the spine causing discomfort, tightness, stiffness, or soreness in your ____ Neck ____ mid ____ Low back which is it for you?

What other health problems should we be aware of?

_____

Do you ____ Smoke ____ Drink? Take any medications _____

Any surgeries _____ Broken bones _____

Family history of _____ Cancer _____ Heart disease _____ Kidney disease _____ diabetes _____asthma

Thank you for this information. Now we will proceed with further testing.

Rate the patient's current difficulties with the various daily living activities. Use a scale from 1 to 5 to rate the levels of difficulty.

1. I can do it without pain and difficulty

2. I can do it without much difficulty but it causes some pain

3. I can manage to do it by myself, but it causes increasing pain

4. I can't do it without help of another person or medication due to pain

5. I can't do it at all due to pain

Difficulties with Self-care and Hygiene:

Bathing or showering ____ Washing, drying, or combing hair ____ Washing face ____ Brushing teeth ____
Making beds ____ Putting on shirts ____ Putting on pants ____ Putting on or tying shoes ____
Cooking or eating meals ____ Washing dishes ____ Taking out trash ____ Doing laundry ____
Using the Restroom ____

Difficulties with Physical Activities:

Standing ____ Sitting ____ Walking ____ Stooping ____ Squatting ____ Kneeling ____ Reclining ____
Reaching ____ Bending forward or backward ____ Twisting left or right ____ Leaning left or right ____
Standing for long periods _____ Sitting for long periods ____ Walking for long periods ____ Kneeling for long periods ____

Difficulties with Functional Activities:

Carrying large or small objects ____ Carrying a purse ____ Climbing stairs or inclines ____ Lifting weights off the table or floor ____ Exercising upper body and arms ____ Exercising lower body and legs ____

Difficulties with Recreational Activities: (if you don't normally do these, don't rate them)

Bowling ____ Jogging ____ Swimming ____ Golfing ____ Dancing ____ Hunting ____ Fishing ____
Cheerleading ____
Hobbies ____ Baseball ____ Football ____ Dating ____ Dining out ____ Volleyball ____ Softball ____
Basketball ____ Horseback riding ____ Others (not listed) _____

Difficulties Traveling:

Driving ____ Driving for long periods ____ Riding ____ Riding for long periods ____

Difficulties with Communication:

Reading ____ Writing ____ Using a keyboard ____ Speaking ____ Listening ____ Concentration or focusing ____

Difficulties with Hand functions:

Grasping ____ Holding ____ Pinching ____ Sensory Discrimination (can you tell what an item is by touch only) ____

Difficulties with Sleeping and Sexual functions:

Being able to have a normal restful full night sleep ____ Being able to perform desired sexual activities ___

EHLICH CHIROPRACTIC CLINIC DISCLOSURE FORM FOR HEALTH PRACTICE AND OFFICE

PROCEDURES IN ACCORDANCE WITH THE NEW HIPAA PRIVACY LAW

I WILL PERMIT THE EHLICH CHIROPRACTIC TO:

1. The office staff may call me at work regarding any appointment changes: **YES** or **NO**
2. The office staff may leave a message, at work, for me to call Ehlich Chiropractic Clinic back if necessary: **YES** or **NO**
3. The office staff can text me, via my cell phone, any info about my appointments or my care: **YES** or **NO**
4. The office staff can call my home to inquire about my healing after care: **YES** or **NO**
5. The office staff can call or leave a message on my home answering machine for any information regarding my care. Others may be able to hear this message: **YES** or **NO**
6. I understand that the adjusting rooms are OPEN at Ehlich Chiropractic Clinic: **YES** or NO
7. I understand that, if necessary, private adjusting rooms are available at Ehlich Chiropractic Clinic, and will be provided upon request: **YES** or **NO**
8. I would like to allow a friend, or family member, to be present in the adjusting room during my care, or during any consultation that the Dr. deems necessary: **YES** or **NO**
9. The office staff may send information or any form of correspondence to me at the address I have provided: **YES** or **NO**

PERMISSION FOR HEALTH INFORMATION RELEASE:

I give permission to the doctors, and staff, of Ehlich Chiropractic Clinic to release information regarding my care to the following people I list below. (This may include, but is not limited to, exams, adjustments, x-rays, appointments, etc.)

_____

_____

_____

APPOINTMENT MAKING RELEASE:

I want **ONLY** myself to make, or cancel, my own appointments: **YES** or **NO**

INSURANCE INFORMATION RELEASE:

I understand that my personal information is required to bill my insurance(s). The information is required for any insurance company to cover my services and bills at Ehlich Chiropractic Clinic. I fully understand that by signing below, I give Ehlich Chiropractic Clinic the authority to disclose this information **ONLY** as necessary to bill **MY** insurance for **MY** services. If at any time I choose NOT to allow the disclosure of my information for the purpose of billing my insurance, I understand that I will become 100% responsible for covering any fees that are accumulated by services that are performed in my spinal correction through chiropractic care.

YES Please bill my insurance, which will include the disclosure of my demographics.

NO I will cover all charges on my own.

PATIENT SIGNATURE AND DATE: _____

NOTICE OF ABILITY TO WITHDRAW:

I understand that I may withdraw any, all, or partial elements of this consent form. I understand that in order to do so, I must provide a written authorization of each area of the consent form that I wish to change. I understand that after signing below, any information on this consent form is valid as of the date of signature, until otherwise stated in writing.

PATIENT SIGNATURE AND DATE _____

Ehlich Chiropractic Clinic
OFFICE POLICIES

Welcome to our office! Your health is our utmost concern, and you can be assured that we will attempt to achieve the best correction in the shortest amount of time possible. It is our experience that our patients achieve the best results when they adhere to these guidelines.

Payment

We expect you to honor your financial obligations. The cost of your initial visit will vary, depending on the nature and severity of your problems, and whether you have active health insurance. You will be informed of the cost of your first visit before any services are rendered, and payment can be made at the end of that visit. Payment for future adjustments is required when you sign in for each adjustment. The fee for a routine adjustment is $40.00 each visit. If your case requires additional therapies that are not included in the cost of your adjustment, additional payments should be made at the end of your visit. These additional costs may include, but are not limited to, the following: EMS ($15), traction ($15), and myofascial release ($25). **Again, payment for your routine adjustment should be made at the time you sign in.**

Standard X-rays

A full set of spinal x-rays costs $110.00. If additional views are needed, each extra x-ray costs $20.00 $50.00, depending on your specific case requirements. You will be informed of the cost of any x-ray before the service is provided. Our doctors WILL NOT provide spinal care without x-rays.

Examination and Other Service Fees

A standard chiropractic examination will be performed on your first visit. The cost will range from $40-$115. Additional services available include EMS, traction, myofascial release, and therapeutic exercises. Ems is electrical stimulation ($15). Traction is used to put the curve back in the spine ($15). Myofascial release is a deep tissue massage that aids in reducing lactic acid and muscle spasms ($25). Therapeutic exercises will be administered as necessary by the doctor ($25).

Second Visit on the Same Day

A regular office visit costs $40..00. Patients that decide on their own to come back on the same day for another treatment will be charged an additional $40.00. However, if the doctor(s) tells you SPECIFICALLY to come back that same day, there will be only one charge of $40..00. Please don't ask the doctor(s) if you can come back the same day. If the doctor(s) feel you require a second treatment they will advise you so.

Re-examination and Progress Reports

Periodic re-examinations will take place during your treatment series. These examinations will enable us to measure your improvement and determine the necessity for further treatment. A brief report on the findings will follow your next appointment. If you have an injury or fall, and as a Medicare patient wants Medicare to consider payment for your visits, you will have to pay for an exam. The cost of the exam is $40.00. The exam is used as evidence of your injury. Medicare does not cover.
this charge, and you will be expected to pay for the exam on the date that it is performed.

Consultations

The doctor(s) is more than happy to discuss any problems you may be having. Please call for a consultation with the doctor, at no additional cost to you.

Cancellation or Changing of Appointments

We have a specific course of treatment for you. A certain number of adjustments in a set amount of time are required to get the results we both desire. Thus, if you need to change the time of your appointment, please arrange a different time on that same day, if possible. **ALL MISSED APPOINTMENTS MUST BE MADE THE NEXT DAY IN ORDER TO MAINTAIN YOUR ADJUSTMENT SEQUENCE. IN THE EVENT YOU ARE UNABLE TO MAKE A SCHEDULED APPOINTMENT, YOU MUST CALL AND CANCEL TO AVOID THE $20.00 CHARGE FOR MISSED APPOINTMENTS.**

Doctors

You have the advantage of two doctors in this clinic. Both doctors will be correcting your subluxations.

Insurance

Please bring your insurance card and any other insurance information with you. We will bill your insurance once every week. If you have met your deductible, you must pay your copay or coinsurance each visit. If you choose to pay for your care by the week, you may write a check for that week's care at the BEGINNING of the week. In the event your insurance does not pay, the balance of the cost of services will become your responsibility.

SIGNATURE: _____ DATE:_____

Ehlich Chiropractic Clinic Mission Statement:

Our mission in this office is to EDUCATE and ADJUST as many families as possible in this area, bringing them back to optimum health through natural CHIROPRACTIC care.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our privacy pledge to you

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information. They are as follows:

1. Another health care provider or hospital may deem our information necessary for diagnosis, assessment, or treatment of your health condition.
2. Any billing party that is responsible for the payment of your services here.
3. Lastly, we may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this form (§164.520). We reserve the right to change our policy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of these documents.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of our health information, please let us know in writing. We are not required to agree with your restrictions. However if we do agree, the restrictions are binding on us.

Your right to revoke your authorization.

You may revoke your consent to us at any time; however, if you do, the revocation must be in writing. If we have already released your health information before receiving your request, we will not be able to honor that request. If you were required to give your authorization as a condition of obtaining insurance, the company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to the above terms. I know that I can have a copy of this notice if I so request.

_____ _____

Printed name Signature and date

EHLICH CHIROPRACTIC CLINIC
5895 CHESNEE HWY
CHESNEE, SC 29323
PHONE: 864-461-2313
FAX: 864-461-2312

If you are filing insurance, please be aware that all of the charges from this visit may not be covered. The charges that may not be covered are the exam and part of the X-rays. You will be responsible for these charges up front. These charges usually equal $70.00. We will bill the insurance company at our discretion. If insurance does cover these charges, we will reimburse you, or credit your account. You understand that insurance may or may not be billed for all of the charges on the date of service in question.

Patient Signature _____

Printed name _____

Date _____

NOTICE OF LIABILITY TO INSURANCE CO.

Enclosed, please find the claim form and assignment of benefits signed by my patient, _____.

If for any reason you are not able to honor this assignment and make payment directly to me, I will assume that you will accept this assignment and be bound by its terms.

Sincerely,

Dr. d'Artagnon L. Ehlich, D.C.

ASSIGNMENT OF BENEFITS

For value received, I hereby assign all of my rights, title, and interest to collect and receive the benefits and sums payable otherwise to me by _____, Group # _____ for and on account of the services set forth on the attached claim for(s) provided me (or in case of my spouse or minor child) to d'Artagnon L. Ehlich D.C., their heirs, successors, or assigns. Payments should be mailed and payable to:

d'Artagnon L. Ehlich, D.C.
5895 Chesnee Hwy
Chesnee, SC 29323

This payment shall not exceed my indebtedness to the above-named assignee and I understand and agree to pay, in a current manner, any balance of said professional charges over and above said insurance payment, GOOD UNTIL CANCELLED VIA WESTERN UNION.

I have read and been provided a copy of this agreement and understand that in the event, by inadvertence, any check or payment should come to me from the insurance company, that I am not entitled to keep the same buy must immediately, pursuant to the terms of this assignment, deliver the same to Dr. Ehlich.

Copies of this original are to be accepted as this original until care is closed by Dr. Ehlich.

DATE _____ _____

(Signature of the Insure person)

WITNESS _____ _____

STRESSFUL SITUATION OCCURS

⇩

INITIATES FIGHT OR FLIGHT

⇩

INCREASES HEART RATE, INCREASES BLOOD PRESSURE,
DECREASES SEX GLANDS, DECREASES SEX DRIVE,
DECREASES DIGESTION, DECREASES FERTILITY,
DECREASES GROWTH HORMONE & CELLULAR IMMUNITY

⇩

ADRENAL GLAND TRIGGER –
RELEASE OF ADRENALINE / EPINEPHRINE

⇩

AMYGDALA

⇩

INCREASES EMOTION, INCREASES ANXIETY, INCREASES
DEPRESSION, DECREASES MEMORY, DECREASES LEARNING
& DECREASES ABILITY TO FOCUS

⇩

HIPPOCAMPUS

⇩

INCREASES LDL, DECREASES HDL, INCREASES FAT STORAGE –
FOR WEIGHT GAIN & TRIGLYCERIDES, INCREASES CORTISOL
HORMONES, INCREASES GLUCOSE PRODUCTION,
DECREASES INSULIN PRODUCTION,
INCREASES BLOOD CLOTTING (STROKES & HEART ATTACKS)
DECREASES MUSCLE STRENGTH, INCREASES CHRONIC PAIN,
INCREASES FATIGUE (CHRONIC FATIGUE), FIBROMYALGIA,
INCREASES BONE LOSS