Thrive Chiropractic
Amplify Your Life

353 Saratoga Rd.
Glenville, NY 12302
518-399-3810
Chiropractor@thriveglenville.com

Name _____ Date _____ Age_____ Male Female

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Cell Provider _____

Email _____ Date of Birth _____

Employer's Name _____ Position _____

Appointment Reminders: Text _____ Email _____ Both _____

Single Married Divorced Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

Whom may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1=mild 10=unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES NO

CHIROPRACTOR? _____ MEDICAL DOCTOR? _____ OTHER _____

WHO AND WHEN? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES NO

IF YES, DR. AND DATE: _____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES NO FRACTURED A BONE? YES NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA _____

_____

✓ *CHECK ALL CURRENT PROBLEMS YOU HAVE*

ADD/ADHD	**BLADDER PROBLEMS**	**DIZZINESS**	**HEART PROBLEMS**	**KNEE PAIN**	**MIGRAINES**	**NUMBNESS IN LEGS**
ALLERGIES	**BEDWETTING**	**DISC PROBLEM**	**HIGH BLOOD PRESSURE**	**LEG PAIN**	**NAUSEA**	**PREGNANCY ISSUES**
ANXIETY	**CANCER**	**EAR INFECTIONS**	**HIP PAIN**	**LIVER DISEASE**	**NECK PAIN**	**SCIATICA**
ARM PAIN	**CHEST PAIN**	**EPILEPSY**	**IMMUNE DEFICIENT**	**LOW BACK PAIN**	**NERVOUSNESS**	**SHOULDER PAIN**
ARTHRITIS	**CHRONIC FATIGUE**	**FIBROMYALGIA**	**INFERTILITY**	**LUPUS**	**NUMBNESS IN ARMS**	**SINUS INFECTIONS**
AUTISM	**COLIC**	**GASTRIC REFLUX**	**IRRITABLE BOWEL**	**MENSTRUAL ISSUES**	**NUMBNESS IN HANDS**	**STOMACH ISSUES**
AUTOIMMUNE	**DEPRESSION**	**HEADACHES**	**KIDNEY PROBLEMS**	**MID BACK PAIN**	**NUMBNESS IN FEET**	**THYROID PROBLEMS**
OTHER:						**VERTIGO**

✓ *CHECK ANY CONDITION THAT YOU HAVE NOW OR HAVE HAD*

__STROKE __HEART DISEASE __SPINAL SURGERY __SEIZURES __SPINAL FRACTURE __SCOLIOSIS __DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS _____

_____

LIST ALL OVER THE COUNTER AND PRECRIPTION MEDICATIONS AND SUPPLEMENTS YOU ARE ON _____

_____

_____

HOW MANY ALCOHOLIC DRINKS DO YOU CONSUME PER DAY _____ PER WEEK _____

HOW MANY CIGARETTES DO YOU SMOKE PER DAY _____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

PRINT NAME DATE

PLEASE PLACE AN "X" IN THE APPROPRIATE BOXES BELOW

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SINUS TROUBLE					
SURGERIES					
TMJ					

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve function through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, involves the application of a specific direction of thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over 1 million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, it's nature, duration, or cost, in what we work to maintain as a supporting open environment.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis. By my signature below, I have read and fully understand the above statements.

_____ _____

Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of healthcare while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondarily to chiropractic care include: soreness, sprain/strain injuries, irritation of a disc condition, and rarely, fractures. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patient may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with the care plan on the second visit.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. I have been advised of the possible consequences is no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and treatment.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

_____

PRINT NAME

_____ _____

SIGNATURE DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN ON NEXT PAGE

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. AMY DONOVAN AND ANY AND ALL THRIVE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATION, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY THRIVE CHIROPRACTIC.

_____	_____	_____
DATE	**GUARDIAN SIGNATURE**	**RELATIONSHIP TO MINOR**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW:

_____	_____
PARENT/GUARDIAN'S NAME	DATE

_____
RELATIONSHIP TO MINOR/CHILD

OPTIONAL:

IN ADDITION, BY SIGNING BELOW, I GIVE MY PERMISSION FOR THE ABOVE NAMED MINOR PATIENT TO BE MANAGED BY THE DOCTOR EVEN WHEN I AM NOT PRESENT TO OBSERVE SUCH CARE.

PRINTED NAME OF PERSON LEGALLY AUTHORIZED TO SIGN FOR

_____
PATIENT

_____	_____
SIGNATURE	RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessment and physician certifications.
4. We may ask your permission to use you as a success story to help others see the value of care in our center. We will ask you to sign a separate consent form if this is the case.
5. If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you a reminder by text message or email.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose, to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

My signature acknowledges that I have read this notice, I understand it and I hereby agreed to comply with the policies as explained here.

_____ _____

Signature Date

Our mission is to deliver exceptional comprehensive care to all of our patients. We believe in improving, educating, and maintaining optimal health for everyone in a professional and compassionate environment. We promise to devote ourselves to excellence and always remain open-minded to possibilities, keeping up with ever changing advances in health science. We are a family style practice, where everyone finds himself or herself comfortable, and where our chiropractic team is enthusiastic and caring to our patients and one another. Our goal is to build long lasting relationships where our patients feel right at home.

Appointment Change:

We respect the importance of your time, and we work very hard to schedule appointments that can accommodate the busy scheduling needs of our patients. In return, we ask that you make every effort to keep the reserved appointments. Broken and missed appointments create problems for other patients, as well as for the practice. If you must change an appointment, we recommend a **minimum of 24 hours' notice** so that we can accommodate another patient. **All patients who fail to cancel and or reschedule the appointment within 24 hours of their appointment will be charged a $25 cancellation fee. Patients who don't contact us and don't show up to their scheduled appointment time will be charged the full $40 appointment fee.** If you were scheduled for a Monday appointment that you need to change, we must be notified no later than 12 PM on the Saturday prior.

Insurance:

Unless arrangements have been approved in advance by our staff, **Thrive Chiropractic** is a cash practice and payment in the form of cash, check, or credit card is expected at the time services are rendered. We realize that temporarily financial problems may affect your timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems arise, we encourage you to contact our office promptly for assistance in the management of your account. We will provide you with the necessary documentation so that you may submit to your insurance company and collect on your claims. ***Please understand that your insurance benefit is a contract between yourself and your chosen insurance company. It is your responsibility to know and understand your own insurance plan, including in-network or out-of-network chiropractic benefits. No Chiropractic insurance plan will cover all Chiropractic needs, and not all services (such as exams, and x-rays) are a covered benefit. Any treatment is your financial obligation, regardless of your chiropractic insurance.***

Medicare Patients

Please understand that Medicare only pays for ACUTE DYSFUNCTIONAL CARE- they do NOT pay for maintenance/chronic care. If you are functional, there are no covered chiropractic benefits. Thrive Chiropractic will NOT provide a superbill to Medicare patients.

We are very happy to welcome you as a new patient!

Signature_____Date:_____

Printed Name:_____