Cave Chiropractic and wellness
LIFE, connected.

Dr. Zach Jaskinia

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____ **Referred by:** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____ **Office Phone:** _____

Email Address: _____

Birth Date: _____/_____/_____ **Gender:** Male Female **Marital Status:** M S W D **No. of Children**_____

Occupation: _____ **Years on Job:** _____

Emergency Contact Information:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Primary Care Physician (PCP): _____ **Phone Number (PCP):** _____

Imaging taken within the last 3 years: X-ray -date taken: _____ **MRI** -date taken: _____ **Other** -date taken: _____

Labs (blood draw) taken within the last year: date taken: _____ Ordering physician: _____

List Any Medications You Are Currently Taking:

Medication Name	Dosage & Frequency

List Any Supplements You Are Currently Taking:

Supplement Name	Dosage & Frequency

❖ **What area(s) of your life would you like to improve?** (circle all that apply)

Pain relief	Stress relief	Reduced symptoms from chronic illness	Pregnancy advocate
Nutritional support	Quality of movement/ athletic performance	Life/Health Coach	Not sure

❖ **Please List Your 3 Major Health Goals (in order of priority):**

HEALTH HISTORY

(Attach additional sheet of paper if you need more room to write)

❖ **Describe The Health Related Matter That Brings You To Our Office:**

_____

Is It Due To An Accident? ☐ Yes ☐ No Date of Accident: _____/_____/_____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

Have you seen other Chiropractors for this matter? ☐ Yes ☐ No If yes, who? _____

Current Symptoms: (circle all that apply)

Back pain	Shortness of breath	Fever	Circulation problems (cold hands/feet)	Muscle spasms
Neck pain	Dizziness	Joint stiffness/pain	Ringing in ears	Headaches
Numbness/tingling/ weakness in legs	Numbness/tingling/ weakness in arms	History of anxiety and/or depression	Bowel/bladder concerns	Feelings of Hopelessness
Chest pain	Fatigue	Frequent colds	Leg cramps	Sleeping concerns

_____

List All Surgeries And Their Dates:

Surgery performed:	Date:

List All Hospitalizations And Their Dates:

Hospitalizations:	Date:

History of stroke or other Cardiovascular condition:
YES When? _____
NO

List Your Family's Health And Medical History, Past And Current (parents, siblings, children):

Condition:	Family Member:	Condition:	Family Member:
Alcohol dependence		HIV/AIDS:	
Arthritis – Type: _____		Immune System- Weak:	
Birth Trauma		Mental Illness:	
Blood Pressure		Multiple Sclerosis:	
Cancer – Type: _____		Muscular Dystrophy:	
Depression:		Osteoporosis:	
Drug Addictions:		Seizures:	
Headaches:		Stroke:	
Heart Disease:		Thyroid Disease:	
Hepatitis:		Other: _____	

XRAY CONSENT

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

Patient Consent to X-Ray

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-rays.

Patient Signature _____ Date _____

Witness _____ Date _____

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signing this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

Patient Signature _____ Date _____

Witness _____ Date _____

CONSENT FOR TREATMENT OF MINORS (if applicable)

I (We) being parent, guardian or custodian of _____, a minor the

age of _____, do hereby authorize, request and direct Dr. Jaskinia to perform any exam, x-ray and treatment for their condition as he deems necessary.

Parent, Guardian or Custodian signature _____ Date _____

FINANCIAL POLICY

It is the policy of CAVE Chiropractic and Wellness that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment. All patients are responsible to check out with the front desk staff to satisfy any payment due at the time of service.

- **All patients are on a cash basis** and payment is expected at time of service unless previous arrangements have been made with Cave Chiropractic staff. If payment is not received within 15 days of service, the balance due will be charged to the credit card on record in your file.
- This office accepts, MasterCard, Discover, Visa, American Express, HSA, Cash and Personal Checks.
- The Doctor will give you an estimate of the fees for service before they are performed or rendered.
- Any refunds will be processed within 7-14 business days.
- As a patient, it is your responsibility to take care of payment(s) on a weekly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.
- This office will provide you with a Super-bill upon request to be sent to your insurance company, if desired. Any denied claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
- Client understands that if they wish to stop care prior to utilizing all credits, clients account balance will be prorated based upon the full rate cash fee per visit.
- Clients participating in "CAVE's System of Expansion" membership who decide to terminate before completion understand that remaining balance will be returned, minus one treatment charge ($50).
- Client's participating in the 12-month membership or 12-month maintenance care who decide to terminate before their 12 months have been completed understand that one more monthly payment will be withdrawn before termination.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

_____

Printed Name

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature Date

Guardian's Signature (For Minors):_____ **Date:** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Authorization to Pay/Release Is Granted to: **Cave Chiropractic and Wellness**

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my medical information by CAVE Chiropractic and Wellness (CC&W) and/or the affiliate practitioners that operate within Your Wellness Connection (YWC), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CC&W I understand that diagnosis or treatment of me by CC&W may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. YWC is not required to agree to the restrictions that I may request. However, if YWC agrees to a restriction that I request, the restriction is binding on YWC. I have the right to revoke this consent, in writing, at any time, except to the extent YWC has taken action in reliance on this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review YWC's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of YWC.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of YWC. This Notice of Privacy Practices also describes my rights and the duties of YWC with respect to my medical information. YWC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature	Print Name	Date

Others covered by this agreement: _____

CHIROPRACTIC INFORMED CONSENT
FOR TREATMENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, exercise, cold laser therapy or spinal decompression therapy. Treatment will be administered based on need, and will be explained in detail prior to, and during treatment. Please ask questions as they arise.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care or other procedures from this office. Risk factors have been reduced to the best of our ability.

Please acknowledge consent with full knowledge of the nature, risks and purpose of the evaluation and treatment program.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:** _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____