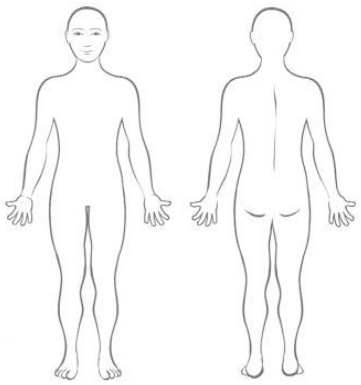
BOYER CHIROPRACTIC INC

David E. Boyer, D.C.
1988 Scotland Avenue- Chambersburg, PA 17201
Phone: (717) 496-0074

Daniel J. Orndorf, DC
9279 Olde Scotland Road, Shippensburg, PA
Phone: (717) 477-0411

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
□ Headache □ Neck pain □ Mid-back pain □ Low back pain
□ Other _____
This is… □ Work related □ Auto related □ N/A
Date Problem Began: _____
How Problem Began: _____

Current complaint (how you feel today):

|_____|

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%
Can you perform your daily activities? □ Yes □ No (describe any current activity limitations) _____
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCANS? □ No □ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: □ None Apply

No	Yes	Condition	No	Yes	Condition
□	□	History of Recent Infection	□	□	Prostate Problems
□	□	Recent Fever	□	□	Frequent Urination
□	□	HIV/AIDS	□	□	Currently Pregnant, # weeks: _____
□	□	Diabetes	□	□	Abnormal Weight □ Gain □ Loss
□	□	Corticosteroid Use	□	□	Epilepsy/Seizures
□	□	Birth Control Pills	□	□	Visual Disturbances
□	□	High Blood Pressure	□	□	Low/Mid Back Pain
□	□	Stroke (date) _____	□	□	Neck Pain
□	□	Dizziness/Fainting	□	□	Arthritis
□	□	Numbness in Groin/Buttocks	□	□	History of Alcohol Use
□	□	Urinary Retention	□	□	History of Tobacco Use
□	□	Aortic Aneurysm	□	□	Nocturnal Pain (pain at night)
□	□	Cancer/Tumor	□	□	Surgeries _____
□	□	Osteoporosis			_____
□	□	Recent Trauma	□	□	Medications: _____
					_____

Family History: □ Cancer □ Diabetes □ High Blood Pressure □ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by Boyer Chiropractic may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or Boyer Chiropractic to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

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First Name: **Middle Initial:**

Last Name:

Street Address:

City: **State:** **Zip Code:**

Home Phone: ( )

Cell Phone: ( )
Cell Carrier: AT&T / SPRINT / Other:_____

Work Phone: ( )

Email Address:

Birth Date: **Sex: M / F**

Social Security #:

Marital Status: M / S / D / W / Sep.

Spouse / Partner's Name:

Appointment Reminder Type: (Circle One)
Phone Call * Text Message * Email * NO Reminder

Referred By:

Employer:

Occupation:

Emergency Contact Name:

Phone: ( )

Child(ren)'s Name(s):

INSURANCE INFORMATION

Please (circle) any and all insurance coverage you or your spouse has applicable in this case:

Workers' Compensation

Auto Accident

Private Medical Insurance

Medical Assistance

Medicare

Self-Pay

HRA OR HSA?

Health Savings Account: (Yes / No)
Amount:

Health Reimbursement Account: (Yes / No)
Amount:

Automobile Accident / Worker's Compensation Claim Info

Insurance Company Name:
Adjuster's Name & Phone #:

Claim Number:
Date Of Accident / Injury:

Name of your Attorney (if you have one):
Attorney Phone Number:

_____

Are You Active Military? (YES / NO)
U.S. Veteran? (YES / NO)

I hereby authorize payment directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

Patient's Signature: _____ **Date:** _____

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I, _____, hereby give my consent to share information regarding my care to the following person/persons, unless this office is notified otherwise.

Name Date Phone #

_____

_____

_____
Signature Date

****

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Boyer Chiropractic.

_____
Name of Patient

_____
Signature of Patient Date
(or patient's personal representative)

((Personal representative information (if applicable))

Name of personal representative_____

Relationship to patient (or other authority)_____

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MEDICARE SIGNATURE ON FILE

New Beneficiary Signature Regulations in effect since April 1, 1982 allow physicians to obtain from the new beneficiary and retain on file a lifetime signature authorization for the physician to submit assigned or unassigned claims in the beneficiary's behalf.

I request that payment of authorized Medicare benefits and any other insurance benefits be made either to me or on my behalf to Boyer Chiropractic for any services furnished me by these physicians. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.

DATE	NAME OF BENEFICIARY	SIGNATURE OF BENEFICIARY	MEDICARE #

BOYER CHIROPRACTIC INC

THIRD PARTY INSURANCE SIGNATURE ON FILE

I authorize Boyer Chiropractic to release to all insurance carriers any medical information necessary to process my insurance claims for myself or my dependents or on our behalf. I understand I am responsible for any services not covered by insurance.

I authorize payment of medical benefits to me or on my behalf to Boyer Chiropractic for any services rendered to myself or my dependents or on our behalf.

DATE	SIGNATURE

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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, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, 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 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, tranquilizers, 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 risks 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 of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my 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 herby give my full consent to treatment.

_____
Patient's Signature

_____
Patient's Printed Name

_____
Date