May Chiropractic
Spine and Neurological Rehabilitation

David A. May, D.C.
Troy M. May, D.C.
918 Apperson Drive
Salem, VA 24153
(540) 387-1680

Patient Name_____Date of Birth_____Telephone:(_____)_____-_____

Address_____ □Male □Female Height_____

Email _____ SSN_____ No. of Children _____ Weight_____

Emergency Contact_____ Relationship_____Telephone:(_____)_____-_____

Occupation_____ How did you hear about our office_____

Reason for visit?_____

_____

Date it began? _____

Describe your current problem:

□ Headache □ Neck Pain □ Mid Back Pain □ Low Back Pain

□ Other_____

How often are your symptoms present?

□ 0-25% (occasional) □ 26–50% □ 51–75% □ 76-100% (constant)

Current Complaint (how you feel today:)

|_____|

0 1 2 3 4 5 6 7 8 9 10

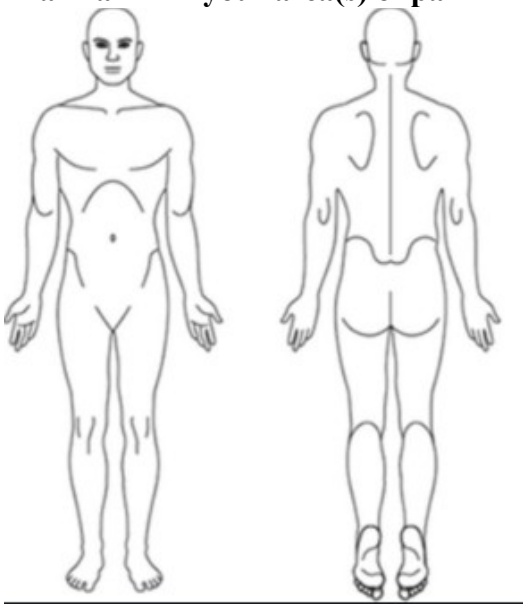
No Pain Unbearable Pain

Have you already received treatment for your condition?

□ Medical Doctor □ Doctor of Chiropractic □ Osteopath

□ Physical Therapist □ Other_____

Mark an X in your area(s) of pain



_____

Medical History

Medical Conditions _____

Accidents/Surgeries _____

Medications _____

Family Medical History

□ Cancer □ Diabetes □ Rheumatoid Arthritis

□ Stroke □ Hypertension □ Heart Problems

□ Other_____

- I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.
- I hereby authorize and direct my insurance benefits to be paid directly to the doctor.
- I am financially responsible for non-covered services.
- I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.
- I certify that this information is true and correct to the best of my knowledge and acknowledge I am responsible for notifying this office of any changes in my status or the above information.

Signature_____ Date_____

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HIPAA Consent & Authorization

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/2018)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to May Chiropractic.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Chiropractor has taken action in reliance on this Consent.

My "protected health 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 protected health 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 have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to be notified of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for the Chiropractor is also posted in the waiting room at May Chiropractic 918 Apperson Drive Salem, VA. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Patient authorizes any family or other persons they request to be present if they so choose while the chiropractor performs treatment, report of findings, medical history and examinations.

The Chiropractor 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 of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Authorization for contact regarding chiropractic care, related health services and/or related health products, appointment reminders and scheduling related matters.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. Also to remind you about scheduled appointments, reevaluations and other appointment related issues. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to-authorize this information your decision will have no adverse effect on your relationship with our staff.

_____	_____	_____
Printed Name of the Patient	Signature of Patient or Personal Representative	Date

_____

Description of Personal Representative's Authority

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

****

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____
Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.