REGISTRATION AND HISTORY

Kevin Sherman, DC
IRONCARE Inc.
Sports Therapy

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____State_____Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account? _____

Relationship to patient_____

Insurance company _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____and assign directly to **Dr. Kevin Sherman** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____Date_____

3 PHONE NUMBERS

Home _____Cell_____

Best phone number to reach you _____

Email Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship_____

Home _____Cell_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

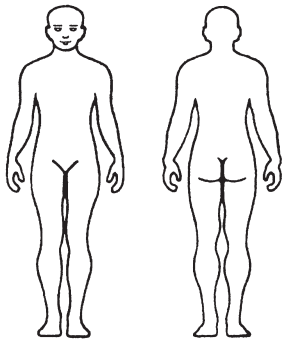
5 PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last physical exam_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No		
Bronchitis	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No		
Bulimia	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No				
Chicken Pox	☐ Yes ☐ No						
Diabetes	☐ Yes ☐ No						

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

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MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

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Informed Consent to Chiropractic/Physiotherapy Treatment

The nature of spinal manipulation: The doctor may use his 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 Active Release Techniques (ART) soft-tissue therapy, hot or cold packs, electric muscle stimulation, therapeutic ultrasound or acupuncture may also be used.

Possible Risks: As with any health care procedure, complications are possible following a spinal 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, bruising, or minor complications.

Probability of risks occurring: The risks of serious 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.
The probability of a serious adverse reaction due to ancillary procedures is also considered "rare", except as described in the following section regarding ART.

Risks associated with Active Release Techniques (ART) soft-tissue therapy include bruising, skin irritation, and increased sensitivity of the injured tissues. These risks are common and not usually serious. ART is an aggressive form of treatment designed to break-up scar tissue and is often performed to the patient's tolerance of pain.

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.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period.

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.

I have had the risks of my case explained to me. I have read the explanation above of chiropractic/physiotherapy 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 Name (print) _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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POLICY REGARDING INSURANCE

This office is pleased to accept your case on assignment as soon as your insurance company and or the responsible party verify your coverage. We will file your claim forms to assist you in every way we can for reimbursement. **We must make it clear that insurance contracts are between you, the patient, and your insurance company. You are responsible for any amount not paid by your insurance company.** By accepting your insurance on assignment, we are extending you credit. This courtesy may be withdrawn if circumstances below warrant.

If you have any questions regarding these policies, ask Dr. Sherman.

1. If you choose to use insurance to subsidize your care in this office you must pay according to the terms of your policy. We will be happy to assist in verifying your benefits.

2. **Coverage is never guaranteed until claims are processed and paid by your insurance company.**

3. Normally, your insurance will pay within approximately 30 days of receipt of claims. If your insurance has not paid within 60 days, then you will be responsible to pay the balance due.

4. We will continue to bill your insurance, as long as you are receiving active care in our office, and as long as you have benefits available to pay for your care.

5. You may be required to sign informed consent, and medical records release forms as well as any other assignment documents required by your insurance company.

6. Our office does not guarantee that your insurance company will pay. We will make every attempt to obtain verification of policy coverage. However, if for any reason your insurance claim is denied, you are responsible for the full amount of your balance.

7. **Coverage is never guaranteed until claims are processed and paid by your insurance company.**

8. Our office will not enter into a dispute with your insurance company over any claims. This is ultimately your responsibility and obligation.

9. Co-payments and fees for non-covered services are due at time of service.

By signing below, you acknowledge that you have read, understand and agree to the above Policy Regarding Insurance.

Patient Printed Name **Signature** **Date**