Fayetteville Chiropractic

Meghann Austin, DC
Fayetteville, AR 72701
(479) 442-0352

COVID-19 SCREENING

1. Have you (or someone in household) traveled outside the state or country in the last 14 days?

2. Have you (or someone in household) had contact with anyone with confirmed COVID-19 in the last 14 days?

3. Have you (or someone in household) had any of these symptoms in the last 14 days?
    - Fever greater than 100
    - Difficulty breathing
    - Cough

_____ _____

Signature **Date**

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The contact information you provide us will be held in confidence and will only be used for documentation in your healthcare file and for contacting you regarding issues related to your care at Fayetteville Chiropractic.

Name: _____Age: _____

Date of Birth:_____ Gender*(circle)* : Male Female

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ E-Mail:_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

How would you like us to contact you for appointment reminders? *(please circle)*

Home Phone / E Mail / Cell Phone / Work phone / Text

Employer _____ Occupation _____

Spouse/Partner *(if applicable)*: _____Phone:_____

Emergency Contact:_____Phone:_____

How were you referred to our office? *(please circle)*

Website / Newspaper article / Seminar / Meeting / Advertisement

Another healthcare practitioner_____ Friend _____Other _____

Are you a student? YES / NO

If yes, what is an alternate address?

_____

In general, please describe what concerns bring you into our office today:

_____

_____

If so, how long ago did these symptoms begin? _____

If you are experiencing any pain or discomfort today, on a scale of 1 to 10 *(1 meaning "very mild" and 10 meaning "extremely severe")*, how would you describe your current symptoms

□ 1 2 3 4 5 6 7 8 9 10 □

Do you have any **allergies** or food sensitivities that you are aware of? Please describe:

_____

_____

Have you ever suffered a fracture or concussion, or have you been in an auto accident? Please describe:

_____

Please circle any surgical procedures you have experienced:

PROCEDURE	**DATE**	**PROCEDURE**	**DATE**	**OTHER (*Please list*)**
Tonsillectomy		Thyroid		
Gall bladder		Stomach		
Back Surgery		Knee		
Dental Surgery		Shoulder		
Female Organs		Foot		
Appendectomy		Rectal		
Hernia		Sinus		

*Please circle or **write in** symptoms that you are experiencing currently or in recent history:*

Energy and Mood	**Gastro-Intestinal**	**Eye/Ear/Nose/Throat**	**Respiratory**
Fatigue	Abdominal pain	Asthma	Chest pain
Anxiety or depression	Gas/bloating	Earache	Difficulty breathing
Poor concentration	Constipation	Hearing problems	Chronic cough
Sudden weight loss or weight gain	Diarrhea		Cold/hayfever/ congestion
Mood swings	Poor digestion	Sinus problems	
Sleep disturbances			
OTHER:	OTHER:	OTHER:	OTHER:
Genito-Urinary	**Musculo-skeletal**	**Cardio-Vascular**	**Skin/Allergies**
Bed wetting	Back pain	High blood pressure	Sensitive skin
			Skin eruptions
Frequent or painful urination	Foot/knee/shoulder or wrist pain	Chest pain	Psoriasis
Blood in urine/stool	Tremors/twitching	Strokes	Eczema
Prostate pain	Joint inflammation	Varicose veins	Bruise easily
		Anemia	
OTHER:	OTHER:	OTHER:	OTHER:

Miscellaneous

Epilepsy
Seizures
Diabetes
HIV/AIDS

Hepatitis _____(A-E, G)

Please list any prescription medications you are currently taking:

_____

_____

_____

Please list any nutritional supplements (vitamins, minerals) you are currently taking:

_____

_____

_____

Have you ever been vaccinated? (please circle) YES NO

If so, when were your most recent vaccinations (including flu vaccination)?

_____

_____

_____

Please share anything else you believe is relevant to your health concerns here:

_____

_____

_____

Are you consulting any other healthcare practitioners for the concerns that brought you into our office today? YES / NO

If so, may we consult with him/her in order to better coordinate your care? YES/NO

Practitioner's Name and Telephone #

_____

The information on this document is true to the best of my knowledge.

_____ / _____

Signature / Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that care/treatment directly and indirectly.
- Obtain payment from third-party payers.
- By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to use my personal information for the purpose of notifying me of a pending appointment, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose personal health information to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out care/treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Signature: _____

Parent/Guardian Signature: _____

Date: _____

OFFICE USE ONLY
I ATTEMPTED TO OBTAIN THE PATIEN'T SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:_____INITIALS_____REASON:_____

FINANCIAL POLICY

Health Insurance

- Dr. Austin accepts assigned benefits for most major health insurance plans. This means you will pay the estimated portion figured by our front office staff at the appointment and the insurance company will send Fayetteville Chiropractic a partial reimbursement check. If there is a credit after insurance pays Fayetteville Chiropractic, then we will send you a refund check.
- If a check is sent to you directly by a payor, or automatically transferred to your bank account, payment to Fayetteville Chiropractic is due within 10 days of receipt.
- Fayetteville Chiropractic files all claims electronically. This should help speed up the process with insurance companies that receive electronic claims.
- Fayetteville Chiropractic allows 90 days for health insurance reimbursement. If insurance does not send payment by this time then the patient or representative is billed for the full balance.

-OR-

Chiro-Health USA (Discount Program)

- Our office participates in the ChiroHealthUSA discount program. This program is implemented to help our patients cover costs of services rendered in this office. This program is initiated by enrolling and paying a $49.00 enrollment fee which will cover you and your immediate family and/or dependents for the entire year (following 12 months' post-enrollment).
- Once enrolled, the first visit will max out at $100.00. Each visit after the initial office visit will max out at $50.00. This includes our therapies, further examinations, spinal manipulations and x-rays performed after the first visit.
- Charges will not be billed to insurance either by us or by you, the patient, if you elect to enroll in this discount program.
- 10% off all our products

IF YOU DECIDE NOT TO ENROLL OR NOT USE INSURANCE, FULL PRICE WILL BE EXPECTED AT THE TIME OF SERVICE

Patient's Signature	**Date**

By signing above, I understand that I have read Fayetteville Chiropractic's financial policy and agree to notify the staff regarding which I wish to be a part of and if I decide to change at any point.

CONSENT FOR TREATMENT

Please initial after each section indicating you have read and understand our office policy.

Request for Records:

I hereby authorize Dr. Meghann Sherman Austin and / or any associates of Fayetteville Chiropractic to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician and health care providers. **Initials**:_____

Payment & Insurance Release:

I permit a copy of this authorization to be used in place of the original by Fayetteville Chiropractic. I authorize release to the Health Care Financing Administration and it's agents any information needed to determine these benefits are payable.
I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.
When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of $30.00 plus any applicable sales tax. The use of a check for payment is my acknowledgment and acceptance of this policy and its terms.
I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I authorize payments of benefits to the provider of service when the provider of service accepts assignment on the claim.
I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection fee, filing fees and attorney fees that are incurred to collect my debt**.** **Initials:**_____

Consent for Treatment of a Minor (IF APPLICABLE):

I (We) being the parent, guardian, or custodians of _____,
A minor, the age of _____, do hereby authorize, request and direct, Dr. Meghann Sherman Austin and /or any other associates to perform in his/her judgment and necessary examinations, x-rays, and recommended treatment for the condition. **Initials**:_____

I understand that my outpatient registration, treatment or series of treatment by Fayetteville Chiropractic is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff.

Date	**Patients Signature**
Witnessed By:	**Parent/Guardian's Signature – if applicable**

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CONSENT FOR RADIOLOGY

I, _____, give Fayetteville Chiropractic, my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office. I also give my consent for films of my child (children) for the same reasons, if applicable.

X-RAYS SHOULD NOT BE PERFORMED IF YOU ARE PREGNANT OR BELIEVE YOU COULD BE PREGNANT. PLEASE NOTIFY THE DOCTOR IF THIS IS THE CASE.
CHECK HERE IF YOU ARE PREGNANT _____

Patient Signature:_____ **Date:**_____

Parent Signature (if applicable): _____

CONSULTATION FORM:

INFORMED CONSENT FOR
INFRARED LASER THERAPY

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Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, pre-existing health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: _____ **Date**: _____

Please Print Name: _____

Date of Birth: _____

Employee Witness _____ **Date**: _____

For Office Use Only:

Patient refused to sign consent form.

Employee Witness: _____

K-LASER USA

Healing

INFORMED CONSENT:

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we used trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think that this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "Extension-rotation-thrust atlas adjustment." We do not do this type of adjusted on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000 – 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Two other potential problems that are ***not*** quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury and spinal dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to urinate or to start a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so many be as short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their incidence. Never put a home ice pack directly on the skin, always have an insulating towel between.

Soreness: it is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complication that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____	_____
Patient's Name Printed	**Today's Date**
_____	_____
Patient's Signature	**Parent or Guardian Signature For Minor**