Paying for your care is easy here!

Mark and initial which one is you:

❑ **No Insurance**

- Easy! Our Cash Plans and simple payment arrangements have helped hundreds of people and will work great for you too!

*Initial*_____

❑ **Medicare**

- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
- After this you will receive a significant Medicare discount. We simply need a copy of your Medicare card.
- Medicare supplements normally pay very little if anything.

*Initial*_____

❑ **Health Insurance and/or Medicaid**

- Insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them. You are responsible for any deductible, co-insurance, co-pays and unpaid visits. Of course you can use your HSA, HRA and Flex here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

*Initial*_____

❑ **Auto Injury**

- Auto related injuries are covered based on reasonable and necessary care in Iowa. Depending on how much you were at fault will determine your reimbursement rate.
- You can get the care you need, and it may cost you much less than regular care. Great for you!
- All we need is your claim number, insurance, and attorney info.
- If you need help finding an attorney, Dr. Knight has recommendations on some that he trusts.

*Initial*_____

❑ **Work Injury**

- In Iowa, the employer decides the healthcare professional to provide you with care. After that you have the option to overturn their decision which sometimes happens, and you are able to pick the healthcare provider.
- The employer can still deny the provider and if you chose chiropractic it is almost guaranteed to get denied in Iowa.

*Initial*_____

ABOUT THE PATIENT

Knight Chiropractic & Functional Health,
1405 Eagle Ridge Road, Le Claire, IA, 52753

Name_____ Today's Date_____ Birthdate_____ Age____

Address_____ City_____ State_____ Zip_____

Phone_____ Social Security Number_____ Gender ❑ M ❑ F

E-Mail Address_____ Have you been to a chiropractor before? □ No □ Yes

Your Employer_____ Type of Work _____

Significant Other's Name_____

Kid's Names and Ages _____

Emergency Contact_____ Phone_____

Referred by: _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Knight Chiropractic & Functional Health to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is the: ❑ Pain today: 1 2 3 4 5 6 7 8 9 10 ❑ Pain at worst: 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Other_____ ❑ Constant ❑ Occasional

❑ Staying the same ❑ Getting worse ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is the: ❑ Pain today: 1 2 3 4 5 6 7 8 9 10 ❑ Pain at worst: 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Other_____ ❑ Constant ❑ Occasional

❑ Staying the same ❑ Getting worse ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is the: ❑ Pain today: 1 2 3 4 5 6 7 8 9 10 ❑ Pain at worst: 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Other_____ ❑ Constant ❑ Occasional

❑ Staying the same ❑ Getting worse ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. What makes it better?_____

5. What makes it worse? _____

6. What Doctors have you seen for this?_____

7. Type of treatment:_____

8. Results: _____

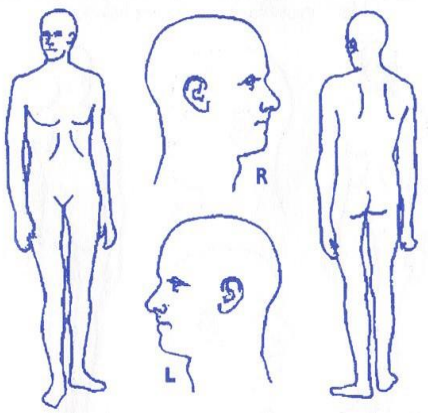
NOTES: _____

_____

_____

Are you pregnant? ❑ Yes ❑ No

Please mark all areas of concern



GENERAL HEALTH HISTORY

Knight Chiropractic & Functional Health
1405 Eagle Ridge Road, Le Claire, IA, 52753

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries:_____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries:_____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Functional Rating Index

Today's Date: _____

Patient's Name: _____ Signature: _____

Instructions:

To accurately assess your condition, we must understand how much your pain has affected your ability to manage everyday activities.

* For each item below, please circle the answer which most closely describes your condition right now *

	0	1	2	3	4
1. Pain Intensity	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
2. Sleeping	Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
3. Personal Care (washing, dressing etc.)	No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need To Go Slowly	Moderate Pain Need Some Assistance	Severe Pain Need 100% Assistance
4. Travel (driving, etc.)	No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips
5. Work	Can Do Usual Work Plus Unlimited Extra	Can Do Usual Work With No Extra	Can Do 50% Usual Work	Can Do 25% Usual Work	Cannot Work
6. Recreation	Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities
7. Frequency of Pain	No Pain	Occasional Pain (25% of the Day)	Intermittent Pain (50% of the Day)	Frequent Pain (75% of the Day)	Constant Pain (100% of the Day)
8. Lifting	No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight
9. Walking	No Pain Any Distance	Increased Pain After 1 Mile	Increased Pain After 1/2 Mile	Increased Pain After 1/4 Mile	Increased Pain With All Walking
10. Standing	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After 1/2 Hour	Increased Pain With Any Standing

WAIVER OF LIABILITY FOR "ROLLER TABLES"

I acknowledge that I and/or my dependent(s) have voluntarily chosen to utilize and operate the intersegmental traction table(s).

I and/or my dependent(s) am/are aware that activities involving the handling of machinery can cause injury.

As consideration for being permitted to operate and utilize the Intersegmental Traction Table(s) in the Knight Chiropractic & Functional Health facility, I hereby agree that I, any assignees, heirs, guardians, and legal representatives will not make a claim against or sue Knight Chiropractic & Functional Health, Inc., its directors, officers, agents, employees for injury.

I and/or my dependent(s) have carefully read this assumption of risk, and I and/or my dependent(s) fully understand its contents. I am aware that this is a release of liability and a legal contract between myself and Knight Chiropractic & Functional Health, Inc. I am signing this document of my own free will.

Patient Name: _____ Signature: _____ Date: _____

Guardian Name: _____ Signature: _____ Date: _____

Other names of dependent(s) less than 18 years of age and covered by waiver:

INFORMED CONSENT TO CARE

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.

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, stokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patient who experience this condition often, but not always, present to the medical doctor or chiropractic with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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 conditions may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescriptions drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

No Call/No Show Policy: If you fail to show up for a scheduled appointment, you may be charged a no call no show fee of $20. Please call in advance if you need to cancel your appointment. Knight Chiropractic also reserves the right to decline your future bookings if this becomes a common occurrence.

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 consent, 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 and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Patient or Guardian:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____