RED ROCK
CHIROPRACTIC
STEVEN C. COX, D.C.

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Your information

Please print clearly or type in the boxes. Ask us for help.

Full name

Date of birth (MM/DD/YYYY)

Preferred name (optional)

Street address, including apartment

City

State

ZIP code

Best phone number

Email

☐ Mobile ☐ Home

Gender

☐ Male ☐ Female ☐ Other

Emergency contact

Name

Phone number

Relationship to you

Medicare or VA patients: please show your card to staff.

Please bring any injury-claim paperwork to the front desk.

Patient name

Your reason for visiting

Tell us about your main concern. Short answers are fine.

What brings you in today?

When did it start?

How did it start?

Is this related to an injury claim? Check one.

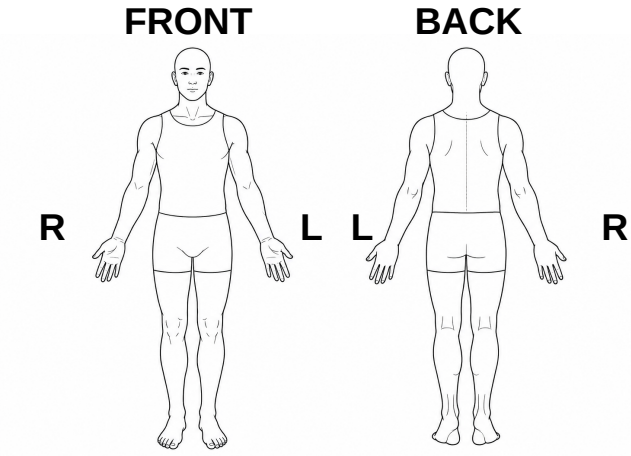
☐ No ☐ Auto ☐ Work ☐ Other injury

If yes, staff will help collect the claim details.

Where does it hurt?

Click an area to add an X. Click again to remove it.

On paper, mark an X. Right and left are yours.



Painful areas (include right or left)

Pain today: select or mark one number.

○ **0** ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

0 = no pain 10 = worst pain imaginable

Patient name

Your health history

Write "none" where appropriate. You may attach a list.

Current medications and supplements

☐ I have attached my medication list.

Allergies and the reaction you have

Current health conditions, past serious illnesses, surgeries or hospital stays (with dates)

Family health history

Check any that apply to your close relatives.

☐ Heart disease
☐ Cancer
☐ Diabetes
☐ Arthritis
☐ Back or disc problems
☐ None
☐ Not sure

Patient name

Symptoms and daily activities

Current = you have it now. Past = you had it before.

Check both if applicable.

Current	Past		Current	Past	
☐	☐	Headaches	☐	☐	Weak grip
☐	☐	Dizziness	☐	☐	Chest pain
☐	☐	Balance problems	☐	☐	Mid-back pain
☐	☐	Fatigue	☐	☐	Low-back pain/spasm
☐	☐	Vision/hearing changes	☐	☐	Buttock or hip pain
☐	☐	Neck pain or stiffness	☐	☐	Leg or thigh pain
☐	☐	Shoulder or arm pain	☐	☐	Foot or ankle pain
☐	☐	Numbness or tingling			

Makes it worse

Helps

How does this affect sleep, walking or daily activities?

Past care, home remedies or X-rays for this concern

Include when and where, if known.

RED ROCK CHIROPRACTIC

Office policies and acknowledgment

Please read each section and sign below. Ask us for help.

Privacy acknowledgment

We respect the privacy of your health information. We may use or disclose health information for treatment, payment, health-care operations, quality control, or when required by law. You may request restrictions in writing and may revoke an authorization in writing, except for information already released. The practice's complete Notice of Privacy Practices is available upon request.

Financial policy

Payment is due at the time of service unless another arrangement has been approved. Red Rock Chiropractic accepts self-pay, Medicare, VA-authorized care, and eligible auto, work-related, or personal-injury claims. Private health insurance is not billed by this office. Patients remain responsible for charges not paid by Medicare, the VA, a responsible insurer, employer, or other third party. For auto, work, or personal-injury matters, promptly provide claim and contact information. Delays or denials do not remove the patient's responsibility for the account. Returned payments, collection costs, or unpaid balances may be charged as permitted by the practice's current fee schedule and applicable law.

Authorization and acknowledgment

I authorize Red Rock Chiropractic to release information reasonably necessary for treatment, billing, claim administration, or coordination of benefits. I authorize payment of applicable benefits directly to Red Rock Chiropractic when permitted. I understand that I am financially responsible for services provided, except where prohibited by law or written agreement.

Patient / representative printed name

Date

Patient / representative signature

Relationship to patient

Office representative

Date

After typing: print the packet and sign pages 5, 6 and 7.

This page summarizes office policies. Ask staff for the complete privacy notice or fee schedule.

PATIENT NAME: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate:
It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated:
It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law:
A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision:
All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation:
This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect:
If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X _____ **(Date)** _____
(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X _____ **(Date)** _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy/physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the office listed below or at any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, I understand and am informed that, as is with all healthcare treatments, results are not guaranteed, and there is no promise to cure. In addition, I understand and am informed that, as with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns from heat lamps, ice or heating devices, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs, such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR: Red Rock Chiropractic, Dr. Steven C. Cox, D.C.

PATIENT SIGNATURE: _____ **Date:** _____

(Or Patient / Guardian / Parent / Representative) (Provide name and relationship if signing for patient)