

# DIAMOND STATE CHIROPRACTIC

1101 Twin C Lane, Suite 201, Newark, DE 19713 302-892-9355

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_

Can we call you at home? \_\_\_\_\_ Can we leave a message? \_\_\_\_\_ Can we call your work? \_\_\_\_\_

Place of employment: \_\_\_\_\_

Name of spouse: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

Employment of spouse: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Primary person responsible: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ PH#: \_\_\_\_\_

Is this visit due to a car accident?  Yes  No

Is this visit due to a work accident?  Yes  No

Reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

Other complaints: \_\_\_\_\_

How did this condition develop and when? \_\_\_\_\_

Similar problem before? If yes explain: \_\_\_\_\_

X-RAYS/MRI's: \_\_\_\_\_ Where? \_\_\_\_\_

Past Chiropractic? \_\_\_\_\_ Where/When? \_\_\_\_\_

Medications: \_\_\_\_\_

Past Surgeries unrelated and related to current problem? Pleased list all: \_\_\_\_\_

\_\_\_\_\_

Pregnant:  Yes  No Last Menstrual Cycle \_\_\_\_\_

Smoker:  Yes  No How many packs/day/week? \_\_\_\_\_

Name/Address/Ph# of Next of Kin: \_\_\_\_\_

Fees are payable at the time of any and all services, unless other arrangements have been made in advance.

I understand that I am responsible for all bills incurred in this office.

I have read the above and understand and have answered truthfully.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security No: \_\_\_\_\_

Email: \_\_\_\_\_ (for promotions and specials)

**OVER ►**

**DIAMOND STATE CHIROPRACTIC:**

**Patient Name :** \_\_\_\_\_

**Date:** \_\_\_\_\_

**SYSTEMS CHECK:**

Please circle if you have had or have any of the following problems: Or is a family member has had please place F by the condition:

**GENERAL**

Headaches

Joint pain

Fever/Chills

\_\_\_\_\_

Dizziness/Fainting

\_\_\_\_\_

Seizures

\_\_\_\_\_

Night pain/Loss of Sleep

Abnormal Weight Loss/Gain

Tremors

HIV/AIDS

Alcoholism

Cancer

Tuberculosis

Hepatitis

Thyroid

Diabetes

Blood disorders

Arthritis

**SURGERIES:**

Please list any other diseases or conditions not listed? \_\_\_\_\_

**EAR/NOSE/THROAT**

No

Yes Explain \_\_\_\_\_

**CARDIO-VASUCULAR PROBLEMS (HEART)**

No

Yes Explain \_\_\_\_\_

**SKIN CONDITIONS**

No

Yes Explain \_\_\_\_\_

**RESPIRATORY PROBLEM (LUNGS)**

No

Yes Explain \_\_\_\_\_

**URINATION OR DIGESTIVE PROBLEMS**

No

Yes Explain \_\_\_\_\_

**WOMEN ONLY**

Menstrual pain

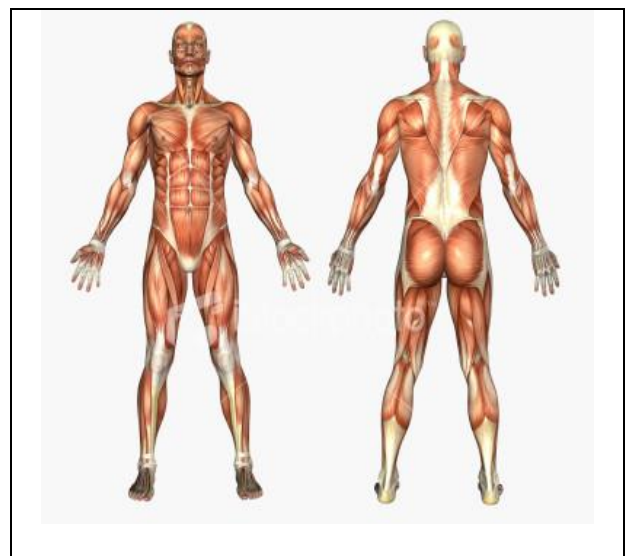
Previous miscarriage

Breast lumps

Menopausal Symptoms

Pregnant  No  Yes

**Please Mark Area of Complaint**



DIAMOND STATE CHIROPRACTIC, P.A.

Kristina A. Hollstein D.C., D.A.B.C.O.

Debbie Skjaveland D.C.

(302)892-9355

Fax: (302) 892-3494

1101 Twin-C lane suite 201

Newark, De 19713

Dear Patient:

Due to the increasing number of patients that do not show for their appointment, DSC will charge a nominal fee of \$5.00-10.00 to those individuals who fail to cancel their appointment.

A patient who fails to show for their appointment or fails to call and cancel within 24 hours prior to their schedule appointment is considered a no show and will be charged the \$5.00-10.00 for a missed appointment.

We do understand that unexpected situations arise which may prevent you from keeping your scheduled appointment and this will be taken into consideration.

By signing of this notice you are confirming you are aware of our **NO SHOW** policy at Diamond Sate Chiropractic.

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Patient Signature

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Printed Name

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Date



## **DIAMOND STATE CHIROPRACTIC, P.A.**

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Debbie Skjaveland, D.C.  
(302) 892-9355 FAX (302) 892-3494  
www.diamondstatechiropractic.com

Christiana Spine Center Building  
1101 Twin-C Lane, Suite 201  
Newark, DE 19713

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

We accept cash, checks, and credit cards. There will be a fee for returned checks for the amount of \$35.

### **REGARDING INSURANCE**

Although every effort is made to obtain accurate information, there are times when the information received is inaccurate or changes throughout the year.

If you have insurance, we will help you receive maximum benefits. We will accept your insurance for procedures; however, in some cases, your insurance will only pay a certain percent. You will be responsible for any balance remaining after the insurance company has paid. It is **your responsibility** to obtain a correct and valid referral. Failure to do so will result in the **full balance being billed to you.**

Insurance is a contract between you and your insurance company. We will handle your claims according to our agreement with your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary", etc. other than to supply factual information that is necessary. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

**IN THE CASE WHERE THE PATIENT RECEIVES DIRECT PAYMENTS FROM THE INSURANCE COMPANY, IT IS THE PATIENT'S RESPONSIBILITY TO FORWARD PAYMENT TO THIS OFFICE.**

### **SIGNATURE ON FILE**

I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor.

I authorize use of this Form for Diamond State Chiropractic to obtain medical information from my other providers. I permit a copy of this authorization to be used in place of the original.

### **MISSED APPOINTMENTS**

Please help us to serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$5.00. Missed appointment fees must be paid prior to seeing the Doctor on your next visit.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_



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# **Informed Consent to Chiropractic Treatment**

Doctors of chiropractic, medical doctors, osteopathic doctors, and physiotherapists, who use manual therapy techniques such as spinal adjustments, are recommended to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments.
- b) There have been reported cases of injury to a vertebral artery following a visit to the primary care physician as well as the supine osseous (face up and “popping” method) cervical spinal adjustments.\* The possibility of such injuries resulting from the supine osseous cervical spinal adjustments is extremely remote and appears to be no different than the risk following a visit to the primary care physician.\* Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasions result in serious injury.
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments, although no specific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given the same symptoms. Chiropractors enjoy the lowest malpractice rates of any health care provider.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

**Please check box if you do not want your neck adjusted using the supine osseous method.**

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness of Signature

\_\_\_\_\_  
Patient Printed Name

\* Neck Pain Task Force of the Bone and Joint Decade 2000-2010, a study sanctioned by the United Nations and the World Health Organization.



## DIAMOND STARE CHIROPRACTIC, P.A.

Kristina A. Hollstein D.C., D.A.B.C.O.  
Debbie Skjaveland D.C.  
(302) 892-9355 (p)  
(302) 892-3494 (f)

Suite 201  
1101 Twin-C Lane  
Newark, DE 19713

[www.DiamondStateChiropractic.com](http://www.DiamondStateChiropractic.com)

### **AUTHORIZATION FOR RELEASE of MEDICAL RECORDS**

This will authorize you to give Diamond State Chiropractic at 1101 Twin-C Lane in Newark, DE 19713 all information you may have regarding my condition when under your observation or treatment. This would include history, findings, x-ray findings, procedures, and diagnosis, as well as subsequent or future developments.

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Diamond State Chiropractic, P.A.**  
**ACKNOWLEDGEMENT OF RECEIPT OF**  
**APRIL 14, 2003 NOTICE OF PRIVACY PRACTICES**

Signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices of Diamond State Chiropractic, P.A.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

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**OFFICE USE ONLY**

Date acknowledgement received: \_\_\_\_\_

OR

Date and reason acknowledgement was not obtained:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)