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:

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

SURGIERIES: ________________
____
____

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 ______________________________________

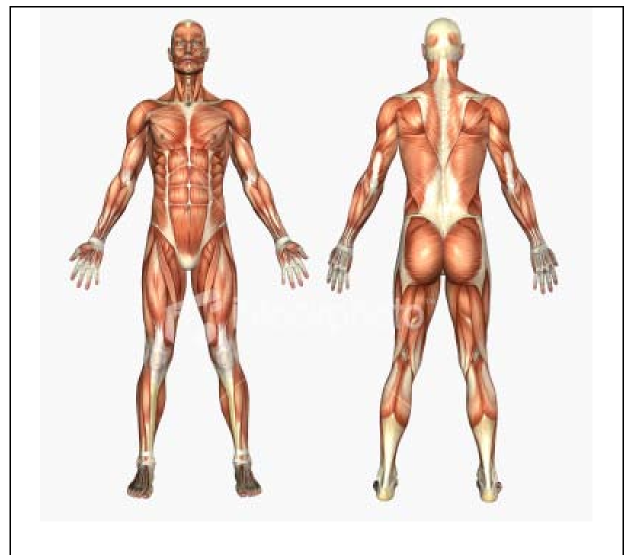
URINATION OR DIGESTIVE PROBLEMS

□ 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.

______________________	______________________	____________
Patient Signature	Printed Name	Date

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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______________

DIAMOND STATE CHIROPRACTIC, P.A.
Kristina A. Hollstein D.C., D.A.B.C.O. Debbie Skjaveland D.C

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with treatment. In particular you should note:

A) while rare, some patients have experienced short term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques;

B) There have been reported cases of stroke associated with common neck movements including osseous adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical osseous spinal adjustment is extremely remote;

C) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific 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 have been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, 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 for the same symptoms.

You may decline osseous adjustments and opt for drop or activator type cervical adjustments.
If you would like to discuss the above further with your doctor or if you have any questions you may refrain from signing until that time when you can discuss any questions you may have with your chiropractor such as the nature and purpose of chiropractic treatment in general and your treatment in particular (including spinal adjustment) as well as the contents of this consent.

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

_______________________________ _______________________

PRINT PATIENT'S NAME ***DATE*** ***SIGNATURE OF PATIENT (GUARDIAN IF UNDER 18)***