Submit by Email | Print Form

Dr. Michael Cohen

Cohen Chiropractic &Wellness

The doctor and staff of Cohen Chiropractic Office welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. PLEASE PRINT CLEARLY!

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Name you would like to be called:_____ Sex: M F Marital Status: Single Married Widowed Divorced Address:

_____ City, State, Zip: _____

SOCIAL SECURITY NUMBER: (MUST BE FILLED OUT). _____ Race:_____

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

Email Address:_____

Would you like to receive appointment reminders? Please select one or both.

☐ Email ☐ By Text Message, please provide cell phone carrier_____

In an effort to reduce paper waste, we would like to offer another option for receiving statements. Please select only one.
I would like to receive my statements by: ☐ Email ☐ Mail

Employment Information

Employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part-time Student ☐ Full-time Student ☐ Other

Employer: _____ Occupation: _____

Responsible Party Information- If you are over the age of 18, please indicate self as responsible.

Relationship to patient: _____ Name (if other than self):_____

Address: _____ City, State, Zip: _____

Responsible Party's Phone#: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone #: _____

Is Your Illness or Injury Related to Any of the Following?

Employment Emergency Accident Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ YES ☐ NO

How Were You referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Location ☐ Website ☐ Other

Please print the name of your source: _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Cohen Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process on information gathering so that the doctor can determine whether to accept me as a patient.

Date: _____ Signature: _____

HISTORY CHECKLIST

Patient Name _____ No. _____

Date of Birth _____ Claim No. _____

Doctor _____ Date _____

Do you have chest pain? ☐ Yes ☐ No

Do you have any change in bowel or bladder habits? ☐ Yes ☐ No

Do you have a sore that does not heal? ☐ Yes ☐ No

Do you have any unusual bleeding or discharge? ☐ Yes ☐ No

Do you have any thickening in your breasts or elsewhere? ☐ Yes ☐ No

Do you have indigestion or difficulty in swallowing? ☐ Yes ☐ No

Do you have any change in a wart or a mole? ☐ Yes ☐ No

Do you have a nagging cough or hoarseness? ☐ Yes ☐ No

Do you have headaches for hours or days? ☐ Yes ☐ No

Do you have blurred vision? ☐ Yes ☐ No

Do you have night sweats? ☐ Yes ☐ No

Do you have pain in your neck, jaw or face? ☐ Yes ☐ No

Do you have a drooping eyelid or and change in your pupils? ☐ Yes ☐ No

Do you have vertigo (dizziness)? ☐ Yes ☐ No

Do you have double vision? ☐ Yes ☐ No

Do you have any visual disturbances? ☐ Yes ☐ No

Do you have any nausea or vomiting? ☐ Yes ☐ No

Do you have any slurred speech? ☐ Yes ☐ No

Do you have any ringing in your ears? ☐ Yes ☐ No

Do you pass out easily (faint)? ☐ Yes ☐ No

Do you take birth control pills? ☐ Yes ☐ No

Do you have a history of stroke in your family? ☐ Yes ☐ No

What prescription medications are you taking if any?

☐ High blood pressure medication

☐ Blood thinners

☐ Other _____

☐ List allergies or adverse reactions to medications

_____

_____

Have you ever had cancer? ☐ Yes ☐ No

Does your pain ever wake you from a sound sleep? ☐ Yes ☐ No

Are you losing weight now without trying? ☐ Yes ☐ No

Are you coughing up blood or noticing it in your stools or urine? ☐ Yes ☐ No

Have you had any loss of bladder or bowel control? ☐ Yes ☐ No

Have you lost consciousness or had double vision recently? ☐ Yes ☐ No

Are you seeing any other doctor for any other reason? ☐ Yes ☐ No

Note: _____

Are you taking any medications or over the counter drugs? ☐ Yes ☐ No

Type: _____

What was the date of the onset of your last menses? _____

Social History

Smoker? ☐ Yes ☐ No

If yes, how many packs? _____

Alcohol? ☐ Yes ☐ No

If yes, how much? _____

Family History

Did your mother or father have any of the following: Put an **M** for mother, **F** for father and **B** for both?

_____ High Blood Pressure
_____ Asthma
_____ Ulcer or Stomach Problems
_____ Thyroid Disease
_____ Heart Attack
_____ Diabetes
_____ Stroke
_____ Circulation Problems
_____ Emphysema
_____ Kidney Disease
_____ Arthritis-Rheumatism
_____ Cancer
_____ Seizures/Convulsions
_____ Pacemaker
_____ Mental Illness
_____ Osteoporosis
_____ HIV Positive

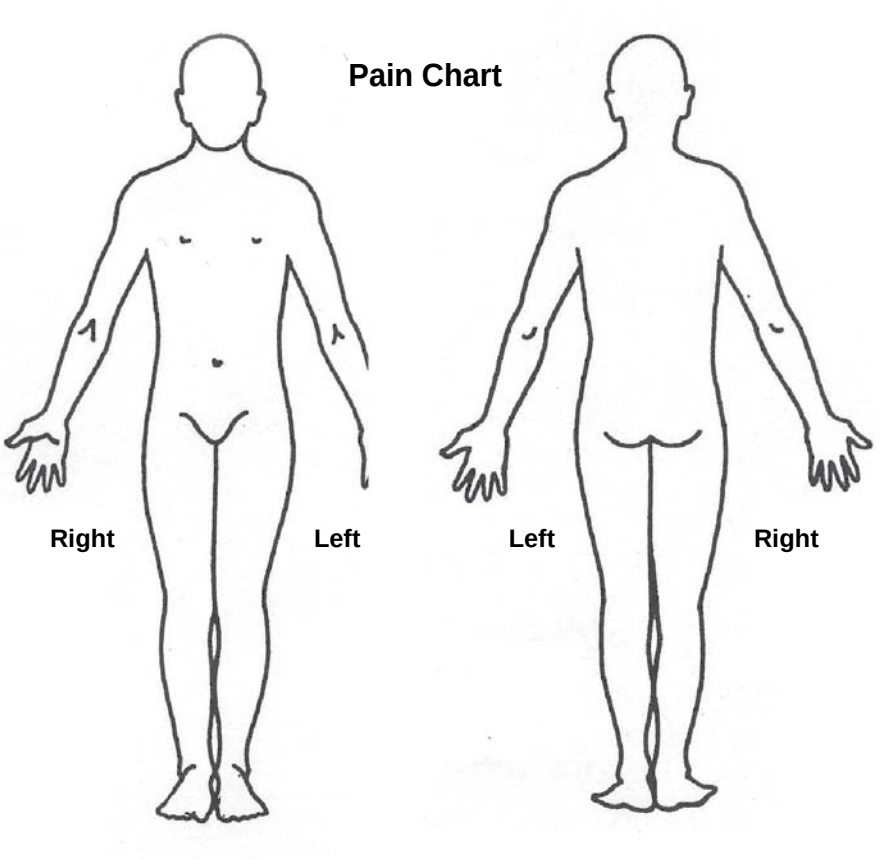
Comments

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark all areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /
- - - - - - -	00000000	XXXXXXXX	********	/ / / / /



Please mark on the pain scale from 0 to 10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.

Pain Scale

Neck-Shoulder-Arm Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 — 10
no pain — severe pain

Mid-Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 — 10
no pain — severe pain

Lower Back Pain
On a scale of 0 to 10.
I rate my discomfort as follows

0 — 10
no pain — severe pain

When did your symptoms begin? _____

Is the pain - constant, frequent or intermittent? _____

Has it gotten worse, better or stayed the same? _____

Date _____ Signature _____

INFORMED CONSENT

Patient Name

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spi-nal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an au-dible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Postural analysis
Range of motion testing	Hot/cold therapy
Muscle strength testing	Vital signs
Radiographic studies	Palpation
Basic neurological testing	Myofascial Release Therapy
Orthopedic testing	Mechanical Traction

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costover-tebral strains and separations and burns. Some types of manipula-tion of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications in-cluding stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reason-able effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some un-derlying weakness of the bone which I check for during the tak-ing of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammato-ries, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this growth may complicate treat-ment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treat-ment. I have discussed it with _____and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date

Patient's Name (Printed)

Patient's Signature

Signature of Parent or Guardian (if a minor)

Date

Doctor's Name (Printed)

Doctor's Signature

FINANCIAL POLICY

The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue–re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments
At Cohen Chiropractic your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your finan-cial obligations without increasing stress in your life.

- If you do not have insurance ALL payments are expected at the time of service. Prepayments are also allowed.
- If you have insurance ALL COPAYS & CO-INSURANCE are due at time of service.
  By taking care of this while you are in the office the need for an invoice is minimized.
- There will be a 1.5% finance charge added to all balances after 60 days.
- There will be a $25.00 charge on all returned checks.
- If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.

Insurance Coverage
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maxi-mum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

X-rays
We will release your X-rays to another doctor only after you sign a release/transfer form and your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail X-rays in time for your appointment.

Appointment/Treatment
Cohen Chiropractic is a very busy clinic and when an appointment is scheduled for you we reserve that time for you only. There will not be a fee for rescheduling or canceling an Adjustment. ***However, For Massage Therapy, there is a $75 fee if a massage appointment is not cancelled more than 24 hours in advance. A credit card must be on file for ALL MASSAGE PATIENTS, no exceptions. The credit card will be on file and charged automatically if there is a no-show or cancellation less than 24 hours in advance.***

Release and Wellness
If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read and understand Cohen Chiropractic office policies and I will honor them.

Patient's Printed Name:

Signature: Date:

Witness: Date:

Credit card on file with us:

Card# Exp Date:

Name as it Appears on Card:

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

_____

Signature