Hello and Welcome to Soft Tissue Solutions

This information sheet is designed to make your visits hassle-free. If you have any questions, please feel free to email or call us before your appointment.

Appointments:

Please allow enough time to deal with traffic issues and find our office.

Your first appointment will last approximately 40 minutes and each appointment thereafter will last approximately 20 minutes.

If you cannot make your appointment, please give us 24-hour notice. This allows us enough time to fill that slot. If you do not show up or do not call to cancel, we will have to charge you for that appointment.

Please have with you:

- Completed paperwork (see the 5 following pages)
- Change of clothes such as shorts, sweats, or a tank top – depending on the treatment area
- Cash, check, or credit card

Location: Farmington Hills

33930 W. 8 Mile Road, Suite 2A
Farmington Hills, MI 48335
248-919-9696

The office is located ¼ mile west of Farmington Road, on the North side.

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

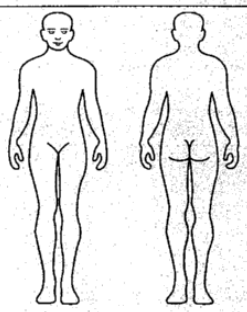
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Chicken Pox ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Other _____
	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that ***Soft Tissue Solution's*** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review ***Soft Tissue Solution's*** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***Soft Tissue Solutions***. The Notice of Privacy Practices for ***Soft Tissue Solutions*** is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and ***Soft Tissue Solution's*** duties with respect to my protected health information.

Soft Tissue Solutions reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or ask for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Soft Tissue Solution's has taken action in reliance on this consent.

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative

Soft Tissue Solutions

Why we have a cancellation policy

One of the toughest policies to implement in any private practice is a cancellation policy. However, without one, a practice is subject to financial loss as a result of appointments that are cancelled without appropriate notice.

At Soft Tissue Solutions, your appointment time is specifically blocked for you. We do not schedule multiple clients for the same time. We value both our time and the time of our patients, so when a person does not show up for their scheduled appointment (no-show) or cancels at the last minute AND we are not able to fill that appointment unfortunately, you will be charged the full fee for that appointment. Since we often have a wait list, not only is this lost income for our practice, but another person does not get to benefit from the services we provide.

Oftentimes, the reasons for missing an appointment are valid – you are stuck in traffic or something unexpected keeps you from getting here on time. Be assured, if you call us and let us know you are running late or cannot make your scheduled time, we will do our best to accommodate you.

As a courtesy to you – we will send you a reminder email or text message a few days ahead to confirm your appointment and you can always let us know if you would like to reschedule. It is however, your responsibility to remember your appointment.

As always, we are so very grateful for your support of our practice. Respecting and acknowledging our cancellation policy makes our practice flow so much easier – we could not do it without you!

Thank you for your cooperation!

_____ _____

Signature of Patient Date

Informed Consent to Care

Soft Tissue Solutions

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, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “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 to 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. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor 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 options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

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

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Parent or Guardian	Signature	Date
_____	_____	_____
Witness Name	Signature	Date