Dr. Wilton Guillory III

Chiropractic Physician

Full Name: ________________________________ DOB: __________________ SS#: ___________________

Address: ____ City, State, Zip: ____________________________

Home #: ______________________ Work #: ______________________ Cell #: _______________________

Email: ____

Height: ___________ Weight: ___________ Referred By: ____

Employer's Name: _____________________________________ Occupation: ________________________

Marital Status: ____________________________ Emergency Contact/Phone Number: __________________________________

REASON FOR VISIT

Please identify the condition(s) that brought you to this office: _______________________________________
____

On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your above complaints.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ________________ When is the problem at its worst? __________________

How did the injury happen? ____

Condition(s) ever been treated by anyone in the past? _____ If yes, when: _________ By whom: ____________

How long were you under care? ________________ What were the results? __________________________

Is condition due to accident? ____________ If yes, when: ____

Type of accident: ____

Attorney Name: ____

Bills mailed to: ____

Please identify ALL PAST and any CURRENT conditions

Injuries: ____

Surgeries: ____

Childhood Diseases: ____

Adult Diseases: ____

List Prescription and Non-Prescription drugs you take: _______________________________________
____

SOCIAL HISTORY

Smoking: ____

Exercise Frequency: ____

How does your present problem affect daily activities, hobbies, work, exercise? ______________________

CHIROPRACTIC EXPERIENCE

How did you hear about us? ____

Have you ever seen a Chiropractor before? ____

If yes, what was the reason for the visits? ______________________________ When? _____________

Name of Previous Chiropractor: ____

INSURANCE INFORMATION

Primary Insurance: ____

Secondary Insurance: ____

Tertiary Insurance: ____

HEALTH HISTORY

Often seemingly unrelated symptoms can manifest as other health concerns. Please indicate any symptoms you have noticed in the past two years.

__ Headaches	__ Dizziness	__ Fainting	__ Fatigue
__ Irritability	__ Depression	__ Loss of balance	__ Asthma
__ Loss of memory	__ Ears buzzing	__ Poor coordination	__ Vision changes
__ Difficulty breathing	__ Shortness of breath	__ Loss of concentration	__ Urinary problems
__ Constipation	__ Diarrhea	__ Weight loss	__ Weight gain
__ Dental problems	__ Irregular heartbeat	__ Chest pressure	__ Digestion problem
__ Sinus congestion	__ Ear pain/infections	__ Allergies	__ Toe walker
__ Upper back pain	__ Neck pain	__ Low back pain	__ Radiating pain
__ Stiffness	__ Reduced mobility	__ Numbness in leg(s)	__ Numbness in feet
__ Numbness in hand(s)	__ Weakness	__ Muscle cramps	__ Sleeping problems

Other: ____

Please indicate any condition you presently **have** or **have had** in the past:

__ Broken bone	__ Disability	__ Diabetes
__ Dislocations	__ Cancer	__ Cerebral vascular
__ Tumors	__ Heart attack	__ Hypertension/high blood pressure
__ Rheumatoid arthritis	__ Osteoarthritis	__ Osteoporosis

__ Other serious condition: ____

DISCLOSURE AND CONSENT FOR CHIROPRACTIC CARE

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. 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 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 or Authorized Person's Signature Date

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practice with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of the privacy notice. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment. If we make a change in our privacy terms the change will apply for all of your health information in our files.

By signing below, you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policies that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

I hereby give lifetime authorization for payment of insurance to be made directly to Wilton Guillory III for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance and/or claims filed for personal injuries. In the event of the default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize these healthcare providers to release all information necessary to secure the payments on any account I owe. A photocopy of this agreement shall be valid as the original.

_____________________________ _______________________________ _________
Printed Name Signature of Patient/Legal Guardian Date

CONSENT TO RELEASE INFORMATION:

In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give consent for Wilton Guillory III, Chiropractic Physician to release my medical records to:

_____________________________ _______________________________ _________
Name of Family Member/Friend Signature of Patient/Legal Guardian Date

WRITTEN CONSENT FOR A MINOR/CHILD

Name of patient who is a minor/child: ____

I authorize Wilton Guillory III, Chiropractic Physician and staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Wilton Guillory III, Chiropractic Physician.

____ ___________
Guardian Signature and relationship to minor/child Date

NOTICE OF CANCELLED AND NO SHOW APPOINTMENTS

Due to the effect that a missed appointment could have on our ability to provide a complete and quality treatment plan, and the increased volume of patients that are in need of clinic appointments, we have established the following guidelines regarding missed appointments:

If an appointment is missed or there is no attempt by the patient to cancel or re-schedule that appointment within 2 hours before the scheduled appointment time, so that another patient can be put into that appointment slot, a charge of $75.00 will be applied to your account.

No show without a phone call = $75.00 charge

When a new patient appointment is made, we will explain this policy, and in the event that new patient's initial visit is not kept or not cancelled 24 hours prior to the scheduled appointment, a $150.00 charge will be applied to your account.

No show for a new patient appointment without a phone call = $150.00 charge

Each patient will be notified about his/her appointment on the business day before the appointment, so that appointments can be confirmed or rescheduled. This policy has been enacted to protect the time of the doctor, staff, and other patients of this office.

Please make it to your utmost concern to arrive at your appointment on time. If for some reason you are unable to keep your appointment please contact our office, and leave a message if necessary, so that we may be able to reschedule your visit.

_______________________________________ ____________

Patient/Legal Guardian Signature Date

NOTICE AND AUTHORIZATION OF COLLECTION SERVICES

I understand if I have an unpaid balance to Wilton A. Guillory, III, DC, LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Wilton A. Guillory, III, DC, LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Wilton A. Guillory, III, DC, LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_______________________________________ ____________

Patient/Legal Guardian Signature Date