Welcome to Cortex Chiropractic & Clinical Neuroscience

Name: _____ Social Security Number: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Telephone Information: *Home:* _____ *Work:* _____ *Mobile:* _____

Email (Optional): _____

Employer: _____ Occupation: _____ Average Hours Worked Weekly: _____

Marital Status: _____ Spouse's Date of Birth: _____ Number of Children: _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Emergency Contact Information: *Home:* _____ *Work:* _____ *Mobile:* _____

Whom can we thank for referring you? _____

List your current treating Doctors (Include Name and specialty)

PCP / Family Care: _____ **Specialist:** _____

Specialist: _____ **Specialist:** _____

What is your Primary Reason for seeking care? _____

Secondary Reasons? _____

Please Describe your Primary Complaint: _____

_____

How do you think this condition started? _____ *Not Sure* ☐

Have you ever had a complaint similar to this in the past? ☐ *No* ☐ *Yes*

Is your complaint related to any particular accident or injury? ☐ *No* ☐ *Yes*

Is your complaint ☐ *Constant (100%)* ☐ *Frequent (75%)* ☐ *Often (50%)* ☐ *Intermittent (25% or less)*

Does anything make your complaint better? _____

Does anything make your complaint worse? _____

Is your complaint ☐ *Getting Better?* ☐ *Getting Worse?* ☐ *Staying the Same?*

Have you been treated for this condition in the past? ☐ *Medical* ☐ *Chiropractic* ☐ *Physical Therapy* ☐ *Other*

Please List All Medications You Are Currently Taking: _____

Please List All Vitamins and Minerals You Are Currently Taking: _____

Please List Any Known Allergies: _____

Previous Illnesses / Hospitalizations ☐ *No* ☐ *Yes*

Previous Injuries, Accidents, Broken Bones, Concussions, Etc ☐ *No* ☐ *Yes*

Previous Surgical Procedures ☐ *No* ☐ *Yes*

When Was Your Last	Less than 6 Months	6-18 Months	Over 18 Months	Never
Physical Exam	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
X-Ray, CT-scan, or MRI	☐	☐	☐	☐

Please Check All That Apply, Presently Or In The Past:

General Health

- O Fever
- O Chills
- O Weight Loss
- O Weight Gain
- O Allergies
- O Stuffiness
- O Sinus Pain
- O Fatigue
- O Trouble Sleeping
- O Weakness
- O Lumps / Swollen Glands
- O Swelling
- O Itching
- O Rash
- O Dry Mouth

Head / Neurological

- O Headache
- O Head Injury
- O Blurry or Double Vision
- O Flashing Lights
- O Sensitivity to Light
- O Earaches
- O Ringing in the Ears
- O Sensitivity to Noise
- O Dizziness
- O Fainting
- O Seizures
- O Tremor
- O Nervousness
- O Depression
- O Memory Loss

Cardio / Respiratory

- O High Blood Pressure
- O Low Blood Pressure
- O Chest Pain
- O Difficulty Breathing
- O Painful Breathing
- O Wheezing
- O Cough (Dry or Wet)
- O Palpitations
- O Bruise or Bleed Easily

Endocrine

- O Excessive Thirst
- O Change in Appetite
- O Hair and Nail Changes
- O Heat or Cold Intolerance

Gastrointestinal / Genitourinary

- O Heartburn
- O Difficulty Swallowing
- O Nausea
- O Vomiting
- O Stomach Pain
- O Change in Bowel Habits
- O Constipation
- O Diarrhea
- O Sweating / Night Sweats
- O Yellow Skin or Eyes
- O Burning with Urination
- O Urgency
- O Incontinence
- O Change in Urinary Patterns / Strength

Musculoskeletal System

- O Neck Pain (R or L)
- O Stiff Neck (R or L)
- O Noises in Neck
- O Head Feels Heavy
- O Pain / Tight Between Shoulder Blades
- O Pain / Numbness in Arms (R or L)
- O Pain / Numbness in Hands (R or L)
- O Pain in Shoulders (R or L)
- O Pain in Elbows (R or L)
- O Pain in Wrists (R or L)
- O Swelling of Joints
- O Pins / Needles in Arms (R or L)
- O Pins / Needles in Hands (R or L)
- O Cannot Raise Arm (R or L)
- O Back Pain (R or L)
- O Stiff Back (R or L)
- O Leg Cramps (R or L)
- O Redness of Joints
- O Pain / Numbness in Legs (R or L)
- O Pain / Numbness in Feet (R or L)
- O Cannot Lift Leg (R or L)
- O Pain in Hips (R or L)
- O Pain in Knees (R or L)
- O Pain in Ankles (R or L)
- O Pain in Feet (R or L)
- O Pins / Needles in Legs (R or L)
- O Pins / Needles in Feet (R or L)
- O Cold Hands / Feet (R or L)

Family History: ***Please Check All of the Following that Apply to Your Direct Relatives***

- O Diabetes
- O High Blood Pressure
- O Heart Disease
- O Pulmonary Disease
- O Stroke
- O Thyroid Disorders
- O Cancer
- O Tumors
- O Muscular Disorders
- O Arthritic Diseases
- O Neurological Diseases
- O Psychological Disorders
- O Autoimmune Disease
- O Connective Tissue Disease
- O Vascular Diseases
- O Other

Habits

Tobacco	☐ **None**	☐ **Yes**	Packs Per Day	_____	For How Long _____
Alcohol	☐ **None**	☐ **Yes**	Drinks Per Week	_____	
Exercise	☐ **None**	☐ **Yes**	Days Per Week	_____	Type _____
Water Intake	☐ **None**	☐ **Yes**	Glasses Per Day	_____	
Coffee	☐ **None**	☐ **Yes**	Cups Per Day	_____	
Soft Drinks	☐ **None**	☐ **Yes**	Amount Per Day	_____	☐ **Regular** ☐ **Diet**

Sleep — Do you sleep soundly all night? ☐ **No** ☐ **Yes** Average Hours per night _____

Do you have difficulty falling asleep or staying asleep? ☐ **No** ☐ **Yes**

Appetite ☐ **Poor** ☐ **Normal** ☐ **Always Hungry** Meals Per Day _____

Stress Levels At Work ☐ **Low** ☐ **Med** ☐ **High** **At Home** ☐ **Low** ☐ **Med** ☐ **High**

I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any members of the staff of Cortex Chiropractic & Clinical Neuroscience responsible for any errors or omissions I may have made in completion of this information.

Patient Signature: _____ Date: _____

CORTEX

CHIROPRACTIC & CLINICAL NEUROSCIENCE

Informed Consent

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests, such as X-rays, MRI or Lab tests, to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatments available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. We encourage you to ask the Doctor any questions you may have so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur. If there is anything you do not understand, please discuss it with the Doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which were supplied in the statement above. Any additional information which may occur will be supplied to you. I hereby consent to chiropractic treatment.

Appointment Cancellation Policy

Below outlines the Appointment Cancellation Policy of Cortex Chiropractic & Clinical Neuroscience.

We respectfully request 24 hours of notice for any appointments that you are unable to attend whereverpossible.

1. We reserve the right to charge a **$50.00 No-Show** fee for patients who do not provide adequate notice.

2. Should you miss two (2) consecutive appointments without notice, all further appointments will be automatically cancelled and reassigned to other patients. Should you wish to reschedule your cancelled appointments, you will need to contact the office to reschedule your future appointments.

3. Worker's Compensation and Personal Injury patients should be aware that we are required by law to report non-attendance to their respective insurers.

I acknowledge that I have read and understand the Informed Consent and Cancellation Policy at Cortex Chiropractic & Clinical Neuroscience.

_____ _____

Signature **Date**

_____

Printed Name

CORTEX

CHIROPRACTIC & CLINICAL NEUROSCIENCE

WAIVER OF LIABILITY for NON-COVERED SERVICES

Our office will provide insurance billing services for you, if you so desire, as a courtesy. Copays are due at time of service. It is your legal responsibility to pay deductible, co-insurance, non-covered services, or services denied by your insurance carrier for any reason. Please notify the front desk if there are changes to your insurance. Failure to do so may result in additional fees. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.

The following services or procedures are *always* denied by your personal insurance carrier when performed by a Doctor of Chiropractic. Payment is due at time of service.

Procedure Code	Procedure Code	Standard Fee
99203	Medicare new patient exam ***Medicare will not cover your initial exam, but will pay for spinal related follow-up treatment***	$130.00
99203	New patient exam-functional neurology, functional medicine	$130.00
10 Neuro	Functional neurology or functional medicine treatment-standard follow-up	$70
20 Neuro	Functional neurology or functional medicine treatment-extended follow-up	$80
S8990	Chiropractic maintenance/chronic maintenance follow-up	$50
0552T	Class 4 laser treatment	$20.00
92540	Basic Vestibular evaluation (Includes 92541-92545)	$300.00
92060	Specialized eye movement evaluation (EyeQ Testing) Reading EyeQ BrainHealth EyeQ Saccadometry Sports Vision EyeQ	 $100.00 $125.00 $100.00 $275.00
92541	Spontaneous nystagmus (observation of unnecessary eye movements)	$100.00
92542	Positional nystagmus (observing eye movements in different head positions)	$100.00
92544	Optokinetic evaluation (Observation of repetitive eye movements)	$100.00
92545	Oscillating tracking test of eye movements (Eye pursuit testing)	$100.00
92548	Computerized Posturography (Balance testing)	$75.00
97750	Physical Performance Testing	$125.00
96120	Neuropsychological testing (Testing memory, reaction time, etc.)	$125.00

Due to the extent of testing that may be necessary at a given initial encounter, we do not charge above $400.00 total regardless of the amount additional testing performed.

I, _____ understand that the above listed procedures are available but in no way are mandatory to have performed. If I choose to obtain the service(s) listed, the fees will be discussed prior to the performance of testing and/or treatment.

_____

Patient's Signature Date

Office Communication and Consent for Use or Disclosure of Health Information

Office Communications

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information as well as agreeing to receiving text message reminders when a cell phone number is provided.

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. They include but are not limited to:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control to other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520, §164.524). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to you health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date