Whom may we thank for referring you to this office? ____________________

APPLICATION FOR CARE AT (Aurora Chiropractic Center)

Today's Date: ______________ HRN: ______________

PATIENT DEMOGRAPHICS

Name: ______________ Birth Date: ____-____-____ Age: ______ ☐ Male ☐ Female

Address: ______________ City: ______________ State: _____ Zip: ________

E-mail Address: ______________ Home Phone: ______________ Mobile Phone: ______________

Marital Status: ☐ Single ☐ Married Do you have insurance: ☐ Yes ☐ No Work Phone: ______________

Social Security #: ______________ Driver's License #: ______________

Employer: ______________ Occupation: ______________

Spouse's Name ______________ Spouse's Employer ______________

Number of children and ages: ______________

Name & Number of Emergency Contact: ______________ Relationship: ______________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: ______________

Secondary: ______________ Third: ______________ Fourth: ______________

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by ***circling the number:***

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ______________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

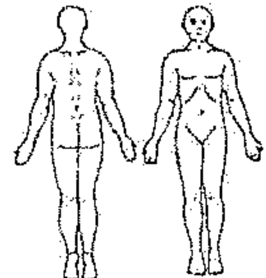
How long does it last? ☐ It is constant OR ☐ I experience it on and off during the day OR ☐ It comes and goes throughout the week

How did the injury happen? ______________

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes If yes, when: ______ by whom? ______________

How long were you under care: ______________ What were the results? ______________

Name of Previous Chiropractor: ______________ ☐ N/A



PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? ______________

What makes your symptoms feel worse? ______________

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
______________:	______________	______________
______________:	______________	______________
______________:	______________	______________
______________:	______________	______________

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If yes, how many times? _________ When was the last episode? ____________________ How did the injury happen? ______________________________

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment: ______________________________, and who provided it: ________________________ How long ago? ______What were the results. ☐ Favorable ☐ Unfavorable→ please explain. ____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have or N for ***Never*** have had:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _________

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
   If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
   Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ______________________

I hereby authorize payment to be made directly to [INSERT CLINIC NAME], for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [INSERT CLINIC NAME] for any and all services I receive at this office.

______________________________ ____-____-____
Patient or Authorized Person's Signature **Date Completed**

______________________________ ____-____-____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: ______________________________ HR#: ______________ Date: ____________

Dr. Steven D. Messerschmidt

Fellow of the Academy of Chiropractic Orthopedists

VERIFICATION OF INSURANCE COVERAGE

Patient Last Name	First Name	Middle

PATIENT NAME

Name ______________________________ Patient/Chart # ______________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

INSURED INFORMATION (POLICY HOLDER)

Name ______________________________ ID # ______________

Policy Name and/or # ______________________________ Group ______________

INSURANCE PAYER INFORMATION

Carrier Name ______________________________

Contact Name ______________________ Fiduciary ______________

Phone # ______________________ Fax # ______________

☐ Employee of Insurance Company ☐ Administrator ☐ Other ______________

O F F I C E U S E O N L Y

COVERAGE DETAILS

Panel Provider? ☐ Yes ☐ No

If no, out of panel provision? ☐ Yes ☐ No

Pre-authorization? ☐ Yes ☐ No

If yes, #: ______________

Deductible (calendar/fiscal) $ ______________

Met? ☐ Yes ☐ No

Co-pay? ☐ Yes ☐ No If yes, amount $ __________

Visit limits per (calendar/fiscal) year __________

Met? ☐ Yes ☐ No remaining visits __________

Fee Schedule Available? ☐ Yes ☐ No

Exclusions/Limits? ______________

Diagnoses: ______________

Procedures: ______________

Other info: ______________

CLAIMS FILING INFORMATION

Accept the 1500 Claim Form? ☐ Yes ☐ No

Mail Claims to: attn: ______________

at: ______________

____

Fax Claims to : ______________

Electronic Claims to: ______________

____

Special Reports Needed? ☐ Yes ☐ No

If yes, when? ______________

Turnaround Time? ______________

Other info: ______________

____

COVERAGE REVERIFICATION

Date ____ / ____ / ____ Spoke to ______________

Changes? ______________

9309 Glacier Highway, Suite B106 • Professional Plaza • Juneau, Alaska 99801
(907) 789-1344 • Fax (907) 789-6134 • E-Mail: aurorachiro@alaska.net

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: ______________________________

____

____

Patient signature: ______________________________ **Today's Date:** __/__/__

Continued on next page

Please mark P for In the Past, C for Currently have, or N for Never

___ Headache   ___ Pregnant (Now)   ___ Dizziness   ___ Prostate Problems   ___ Ulcers

___ Neck Pain   ___ Frequent Colds/Flu   ___ Loss of Balance   ___ Impotence/Sexual Dysfun.   ___ Heartburn

___ Jaw Pain, TMJ   ___ Convulsions/Epilepsy   ___ Fainting   ___ Digestive Problems   ___ Heart Problem

___ Shoulder Pain   ___ Tremors   ___ Double Vision   ___ Colon Trouble   ___ High Blood Pressure

___ Upper Back Pain   ___ Chest Pain   ___ Blurred Vision   ___ Diarrhea/Constipation   ___ Low Blood Pressure

___ Mid Back Pain   ___ Pain w/Cough/Sneeze   ___ Ringing in Ears   ___ Menopausal Problems   ___ Asthma

___ Low Back Pain   ___ Foot or Knee Problems   ___ Hearing Loss   ___ Menstrual Problem   ___ Difficulty Breathing

___ Hip Pain   ___ Sinus/Drainage Problem   ___ Depression   ___ PMS   ___ Lung Problems

___ Back Curvature   ___ Swollen/Painful Joints   ___ Irritable   ___ Bed Wetting   ___ Kidney Trouble

___ Scoliosis   ___ Skin Problems   ___ Mood Changes   ___ Learning Disabilty   ___ Gall Bladder Trouble

___ Numb/Tingling arms, hands, fingers   ___ ADD/ADHD   ___ Eating Disorder   ___ Liver Trouble

___ Numb/Tingling legs, feet, toes   ___ Allergies   ___ Trouble Sleeping   ___ Hepatitis (A,B,C)

QUADRUPLE VISUAL ANALOGUE SCALE

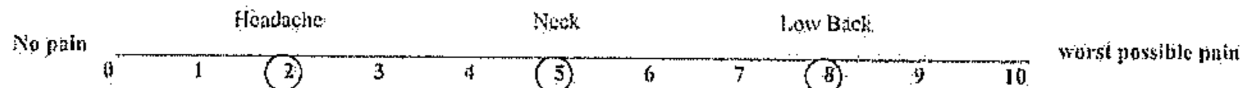
Patient Name ______________________ Date ______________

Please read carefully:

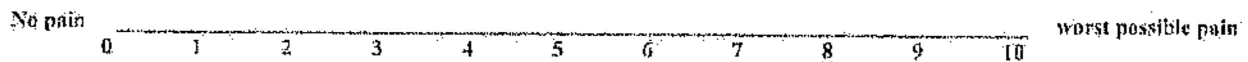
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

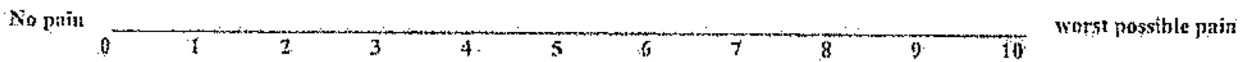
Example:



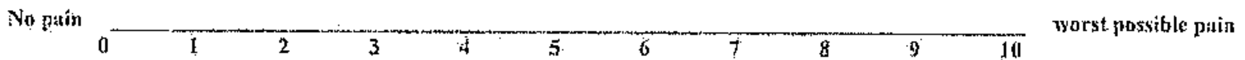
1 – What is your pain RIGHT NOW?



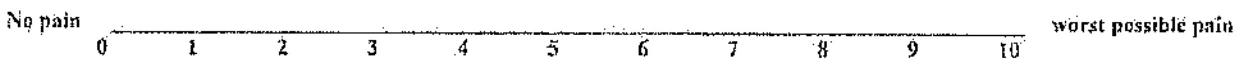
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Dr. Steven D. Messerschmidt
Fellow of the Academy of Chiropractic Orthopedists

The Benefits of Chiropractic Adjustments & Physical Therapy Modalities

1. Restore Motion – Both symmetry and ROM
2. Normalize biomechanics and load distribution
3. Pump out waste products and edematous fluid
4. Improve nutrition to discs and articular cartilage
5. Relax tight muscles
6. Normalize proprioception – position sense and kinesthesia
7. Stimulate sensory – motor reflexes which improve dynamic muscular stabilization of joints
8. Accelerate healing – because movement:
   a. Increases metabolic rate
   b. Increases collagen and protein production
   c. Increases blood flow to tissues
9. Improve the alignment of new connective tissues

Risks *(although rare)*

- ✓ Fracture
- ✓ Disk injury
- ✓ Dislocation
- ✓ Muscle strain

X ____

Signature of patient or person acting on patient's behalf.

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FINANCIAL POLICIES

Aurora Chiropractic Center will bill primary and secondary insurance for all patients. If there is tertiary coverage, we will provide a super bill so that the patient may be reimbursed for any charges not covered by the first two insurance companies.

Payment, in full, is expected at the time of service for all patient portions unless other arrangements have been made. Monthly payment plans are available with no interest accrued unless the balance reaches 90 days past due.

All balances assume full insurance portion payment. The patient is ultimately responsible for any amount that the insurance does not cover.

We can offer a time of service discount to all patients but the balance must be paid in full at the time of service to take advantage of this discount.

MASSAGE THERAPY POLICIES

No show massage clients will be charged 70% of the massage fee. Clients arriving late will be charged the full amount of the massage. We will provide reminder calls but all massage clients are still ultimately responsible for their appointments. We will accept cancellations up to two hours prior or before the close of the business day (5pm), whichever comes first.

For Insurance Patients Only:

I ____, understand that if my provider determines, for any reason, that the services I will or have received in this office are not medically necessary, that I will be responsible for payment of these services.

Patient acknowledges and agrees to the above.

X ____ ________________________

Signature of patient or person acting on patient's behalf. Date

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NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits – to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy – such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatment:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care – you are stable and not making any more improvement.
- Wellness Care – to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is called "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductibles and copayments.

X ____ ____________________

Signature of patient or person acting on patient's behalf. Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X ____ ____________________

Signature of patient or person acting on patient's behalf. Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this for may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

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Dr. Steven D. Messerschmidt

Fellow of the Academy of Chiropractic Orthopedists

Dr. Steven Douglas Messerschmidt, FACO

Email: aurorachiro@alaska.net
Website: akspine.com

Why Chiropractic Adjustments?

What are we really doing? What exactly are we treating? Why are we adjusting the patient and what is the adjustment doing?

Fibrosis is a term given to tissues that have histologically changed, subsequently altering the tissue's mechanics, including its strength, its elasticity, and altering the tissue's neural function. The last phase of the pathophysiological process is fibrosis.

Specifically, the fibrosis of repair renders the tissues:

Weaker:	Flare up of pain and/or spasm at times of increased use of stress
Less elastic:	Increases nociception. Alters mechanoreception.

Many things can initiate the pathophysiological process with the eventual tissue fibrosis, including (anything that initiates tissue inflammation):

- Infection
- Macrotrauma
- Repeated microtrauma
- Chemicals
- Ag-Ab reactions
- Stress
- Radiation

This fibrosis can be found in multiple tissues. Our primary initial goal for our patients is to minimize the magnitude of adverse tissue fibrosis. Consistent efforts to achieve this goal include:

1. Early persistent controlled mobilization
2. Ice
3. Ultrasound
4. Positive currents (galvanic-microamp)
5. Contractile currents
6. Tissue work
7. Exercise
8. Increase essential fatty acids

Once fibrosis is established it must be reckoned with. Consistent efforts to minimize adverse tissue fibrosis include:

- Muscles – exercise, tissue work
- Myofascia – tissue work
- Tendons – adjustments
- Periarticular tissues – adjustments
- Brain – systemic support
- Nerve roots/dural sleeves – adjustments, traction

For all, improved diet, reduction of stress, healthy chemistry, elimination and strength through exercise is recommended.

We use articular adjustments as a means of reducing the pathophysiological alterations in periarticular soft tissues that maintain biomechanical disorder and its structural and neurological effects.

Articular Adjustments for:

Dr. Steven D. Messerschmidt
Fellow of the Academy of Chiropractic Orthopedists

- Subluxations
- Dysfunction
- Biomechanical impropriety
- Aberrant motion
- Altered Instantaneous Axis of Rotation (IAR)
- Juxtapositional disrelationships

Whatever the cause, many musculoskeletal soft tissue disorders and complaints persist due to complications of the fibrotic nature of the reparative process, and from the development of a neuropathic afferent process within these fibrotic tissues.

Our therapy is to reverse or improve these fibrotic tissue changes with motion; and in doing so achieve a local improvement in joint biomechanics, a local improvement in afferent pathways, a systemic improvement in neurological integration, and a subsequent improvement in whole body health. The necessary segmental and periarticular paraphysiological motion required to achieve this goal is best accomplished with a specific adjustment. Our total management of the patient must also include the counseling necessary for the self-avoidance of possible continuing causes of their lesion, and the improvement of the patient's predilecting states for his/her condition.

We must accept the irreversibility of some tissue changes and its associated subtle afferent neuropathies. This signs of tissue fibrosis and its associated neuropathies may be quite subtle and, therefore, not recognized.

Special thanks to Dr. Daniel Murphy

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(907) 789-1344 • Fax (907) 789-6134 • E-Mail: aurorachiro@alaska.net

{Aurora Chiropractic Center } NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health Information, please call (insert name of contact person) at (_____) ________________ If she/he is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _________-retaining *page 1 of 2*

(Insert Practice Name) NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of (insert practice name) Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_______________________________________ ____________ ____________
Patient's Name DOB HR#

_______________________________________ ____________
Patient's Signature Date

_______________________________________ ____________
Witness Date

(Aurora Chiropractic Center)

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at (Insert Practice Name) have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_________________________________ ___/___/___ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_________________________________ ___/___/___ *Witness Initials*

Patient or Authorized Person's Signature Date

Dr. Steven D. Messerschmidt

Fellow of the Academy of Chiropractic Orthopedists

PURPOSE OF YOUR X-RAYS

1. Evaluate for abnormalities of your bones and joints, which could modify your treatment or require other types of treatment, such as bone disease, congenital malformations (anomalies), or fractures/dislocations.
2. Reveal past wear and tear (degeneration) affecting your bones and joints.
3. Analyze the mechanical alignment of your spine and visualize the location of your spinal problems.
4. Allow the development of a treatment plan specifically designed for your condition.
5. Provide a valuable addition to your permanent health care record.
6. Re-x-ray at a later date may be necessary to help evaluate your progress and compare your condition to what it was originally.

AMOUNT OF X-RAY EXPOSURE

Diagnostic x-ray dose is measured in units called rads. X-ray as used in modern health care for diagnostic purposes requires only very small doses and is carefully confined to only the body regions required. In this facility, all skeletal applications require less than a 2 rad dose (estimated skin entrance dose, regional), many times involving only a fraction of one rad. By comparison, x-ray exposure typically required for evaluation of gastrointestinal ulcers or kidney disease involves at least 10 rads, and these procedures have been used for decades with detrimental effects. Patients are routinely able to withstand a regional dose of 6000 rads for therapeutic purposes in cancer treatment.

METHODS WE USE TO MINIMIZE YOUR EXPOSURE & PROMOTE YOUR SAFETY

1. This entire x-ray facility and all of its equipment have passed inspection by and are registered with the Radiological Health Commission of the Alaska State Division of Health & Social Services. All laws, regulations, and recommended safety procedures are scrupulously observed.
2. Only the views needed to diagnose and treat your condition are taken.
3. The x-ray machine in this facility is a high-frequency generator, which produces high-quality images utilizing an average of 1/3 less radiation as compared to typical x-ray machines.
4. Electronic timers control exposures precisely in times as short as 3 thousandths of one second (0.003 sec.).
5. State-of-the-art film and intensifying screens. X-ray film is available in variable speeds, as is photographic film. In addition, luminescent screens are placed in front and in back of each film as the x-ray is taken in order to amplify the image produced, thus allowing the use of a lesser amount of radiation. We use the newest, best, and fastest film and screens consistent with optimum image quality.
6. Collimation. Special lead shutters limit the size and shape of the x-ray beam, so that it is carefully confined to the small area necessary for your particular examination. No unnecessary parts are exposed.
7. Barriers and shields. Lead shielding is used to block x-ray from all unnecessary areas. Gonad shielding, utilized for exposures of the hips or pelvis, is an example.
8. Compensating filters. Special aluminum and/or copper filters placed in front of the x-ray beam reduce the intensity of portions of the beam to compensate for varying thicknesses and densities in your body.
9. Training. Dr. Messerschmidt is a licensed chiropractic physician, holds postgraduate specialty status in chiropractic orthopedics and complies with and exceeds all postgraduate continuing education requirements. He is assisted by trained radiological technicians.

PATIENT CONSENT TO X-RAY

I authorize the performance of diagnostic x-ray examination of myself, which Dr. Steven Messerschmidt may consider necessary or advisable to the course of my examination and treatment.

Signed ______________________________ Date ______________

CONSENT TO X-RAY A MINOR

I am the parent or legal guardian of ______________________, who is a minor, ________ years of age. I authorize the performance of diagnostic x-ray examination of this child or ward, which Dr. Steven Messerschmidt may consider necessary or advisable in the course of examination or treatment.

Signed ______________________________ Date ______________

FEMALES: REGARDING POSSIBILITY OF PREGNANCY

This is to certify that, to the best of my knowledge, I am not pregnant, and Dr. Steven Messerschmidt has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed ______________________________ Date ______________

FEMALES: CONSENT TO X-RAY DURING PREGNANCY

This is to certify that I am or may be pregnant and that Dr. Steven Messerschmidt has my permission to perform diagnostic x-ray examination involving my cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be utilized over the trunk of my body. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed ______________________________ Date ______________

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