



CHRONIC CONDITIONS

Center of Greensboro

530 N. Elam Ave., Suite C,
Greensboro, NC 27403
336-285-7077

Welcome!

The following is information regarding your first visit at Chronic Conditions Center of Greensboro. Your appointment has been scheduled under the assumption that your paperwork will have been completed prior to your appointment time.

When filling out the Symptoms Survey form, please follow the directions carefully. Mark the box "1" for mild symptoms, "2" for moderate, and "3" for severe. If the symptom does not apply to you, leave the box blank.

If you arrive without all your paperwork completed, you will not be seen by the doctor. You will be asked to reschedule your appointment.

When you come in for your appointment, please:

- Bring your completed New Patient Paperwork (enclosed)
- Bring copies of previous x-ray's, MRIs, and lab results
- Please do not wear makeup or fingernail polish on your first visit (will inhibit exam results)
- Please do not chew gum
- Do not drink coffee within 2 hours of your appointment

Please note that our office does not file for your insurance. You may ask for a Superbill that you can submit to your insurance for re-imbursement. We look forward to working with you and re-establishing your health and wellness. If you have any questions, please give our office a call (336) 285-7077.

Kind Regards,
Chronic Condition Center Team

Health and Wellness - Intake Form

Welcome to Chronic Conditions Center of Greensboro. Please be completely accurate and answer each question. Your answers to the following questions are the first step in determining your immediate and long-term health care needs. Please elaborate on any question or add any comments you have...the more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank you!

Personal Information:

Full Name:			Today's Date:	
Date of Birth:	Age:	Height:	Weight:	
Address:				
City:		State:	Zip Code:	
Primary Phone:		Work Phone:		
Email Address:				
Marital Status: M S D W	Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Children:	
Occupation:		Employer's Name:		
Emergency Contact:			Relationship to You:	
Emergency Contact Phone:				
How did you hear about our practice?				

What are your primary reasons for seeking treatment today?

Name _____ Date _____

Causes of Most Pain, Sickness and Disease

For your 1st visit-checkmark any causes you have experienced in last 6 months. For Re-exams-checkmark causes you are currently experiencing.

PHYSICAL	EMOTIONAL STRESSORS	NUTRITIONAL TOXICITIES/ DEFICIENCIES	CHEMICAL TOXICITIES
<input type="checkbox"/> Computer work hours per day	<input type="checkbox"/> Work	<input type="checkbox"/> Eat white sugar	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Repetitive stress activities	<input type="checkbox"/> Home	<input type="checkbox"/> Eat white flour	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> Over Exercise	<input type="checkbox"/> Negative Thinker	<input type="checkbox"/> Drink coffee	<input type="checkbox"/> Toxic Cleaners
<input type="checkbox"/> Under Exercise	<input type="checkbox"/> Divorce	<input type="checkbox"/> Drink Sodas	<input type="checkbox"/> Pesticides
<input type="checkbox"/> Poor Quality Sleep	<input type="checkbox"/> Death of a close family	<input type="checkbox"/> Eat trans fats	<input type="checkbox"/> Fertilizers
<input type="checkbox"/> Sprains/strains	<input type="checkbox"/> Job loss	<input type="checkbox"/> Eat fried foods	<input type="checkbox"/> Workplace Chemicals
<input type="checkbox"/> Concussions	<input type="checkbox"/> Diagnosed with disease	<input type="checkbox"/> Eat fast foods	<input type="checkbox"/> Shower/ Swim in Chlorine Water
<input type="checkbox"/> Car Accidents (please list below)	<input type="checkbox"/> Financial stress	<input type="checkbox"/> Overeating	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Falls (please list below)	<input type="checkbox"/> Difficult childhood	<input type="checkbox"/> Stressed eating	<input type="checkbox"/> Prescription & Over the Counter Drugs (please list below)
<input type="checkbox"/> Sports injuries (please list below)	<input type="checkbox"/> Family issues/conflict	<input type="checkbox"/> Under eating	
<input type="checkbox"/> Broken bones (please list below)	<input type="checkbox"/> Hours watch T.V per day	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Surgeries (please list below)	<input type="checkbox"/> Guilt/ Remorse/ Regret		
<input type="checkbox"/> Stitches	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Other _____			

List all recent accidents, falls, & injuries within the last 6 months:

Date:

Describe:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

List all current prescribed medications:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

List accidents, falls & injuries (physical traumas) BEFORE 6 months ago:

Date:

Describe:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

List all current "over the counter" medications:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

List all hospitalizations, surgeries, broken bones, stitches etc:

Date:

Describe:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Wellness Actions to Prevent Most Pain, Sickness, and Disease

Please checkmark the wellness actions you are doing and fill in appropriate questions.

REST & RELAXATION	MIND, EMOTIONS & SPIRITUALITY	EXERCISE	Frequency / Duration
<input type="checkbox"/> Engage in activities to Distress your body	<input type="checkbox"/> Actively Think Positively Daily	<input type="checkbox"/> Stretching	_____
<input type="checkbox"/> Get 8 hours good quality sleep regularly	<input type="checkbox"/> Express Gratitude Daily	<input type="checkbox"/> Small motor movements activities	_____
<input type="checkbox"/> Take breaks throughout the day	<input type="checkbox"/> Pray	<input type="checkbox"/> Weight train	_____
<input type="checkbox"/> Use a special pillow	<input type="checkbox"/> Meditate	<input type="checkbox"/> Endurance train	_____
<input type="checkbox"/> Use a special mattress	<input type="checkbox"/> Journal	<input type="checkbox"/> Wear orthotics	_____
<input type="checkbox"/> Use black out curtains	<input type="checkbox"/> Emotional Freedom Technique	<input type="checkbox"/> Floss your teeth	_____
<input type="checkbox"/> Cover all light sources including clocks	<input type="checkbox"/> Emotional CPR	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Stop watching TV at least 2 hours before bed	<input type="checkbox"/> Other: _____		_____
<input type="checkbox"/> Turn off Computer at least 2 hours before bed			_____
<input type="checkbox"/> Decrease lighting 2 hours before bedtime			_____
<input type="checkbox"/> Other: _____			_____

NERVOUS SYSTEM & BODY WORK	Reason For Going	Date Of First & Last Visit	Results
<input type="checkbox"/> Chiropractic	_____	_____	_____
<input type="checkbox"/> Massage	_____	_____	_____
<input type="checkbox"/> Physical Therapy	_____	_____	_____
<input type="checkbox"/> Acupuncture	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

NUTRITION	Nutritional Supplements	Reason / Results	List Dietary Changes That Have Worked Well Or Poorly For You In The Past
<input type="checkbox"/> Eat Vegetables Daily	1) _____	_____	1) _____
<input type="checkbox"/> Eat Fruits Daily	2) _____	_____	2) _____
<input type="checkbox"/> Eat Animal Protein Daily	3) _____	_____	3) _____
<input type="checkbox"/> Drink bottled or filtered water daily	4) _____	_____	4) _____
<input type="checkbox"/> Make and Drink Fresh Juices	5) _____	_____	5) _____
<input type="checkbox"/> Avoid Trans Fats	6) _____	_____	6) _____
<input type="checkbox"/> Avoid MSG	7) _____	_____	7) _____
<input type="checkbox"/> Avoid Artificial Sugar	8) _____	_____	8) _____
<input type="checkbox"/> Avoid Refined Flour	9) _____	_____	9) _____
<input type="checkbox"/> Avoid Refined Sugar	10) _____	_____	10) _____

Name _____

Date _____

consistency taking supplements _____ %

7 PILLARS OF HEALTH - SURVEY OF YOUR BODY'S SYSTEMS v3.1**For FIRST VISIT- Rate severity of symptoms below you have experienced in last 6 MONTHS from 0-10 (10 worst) or circle where appropriate****For RE-EXAMS- Rate severity symptoms below you are CURRENTLY experiencing from 0-10 (10 worst) or circle where appropriate****Neuro-hormonal/ Endocrine Pillar #1****Adrenals**

Energy Low/ Variable/ Normal/ High

 Difficulty falling asleep

 Difficulty staying asleep

 Slow to Start in Morning

 Energy Crash _____ am/pm

 Dizzy when stand quickly

 Light Bothers Eyes

 Weak Nails

 Perspire easily or excessively

 Orgasm Quality (poor/ fair/ good/ great)
 Other _____

Pituitary

Sex Drive Flat/ Low/ Normal/ High

 Menstrual Disorders

 Splitting Headaches

 Other _____

Thyroid

Tired/ Sluggish throughout day

 Chills, Feel Cold hands, feet, body

 Require Excessive Sleep

 Increase in weight unexplained

 Difficult infrequent bowel movements

 Depression Lack of Motivation

 Hair Loss and Thinning

 Thinning of Outer Third of Eyebrow

 Dryness of Scalp

 Mental Sluggishness

 Heart Palpitations-Skip/Flutter

 Inward trembling

 Increase pulse at rest

 Insomnia-cannot sleep

 Night Sweats

 Other _____

Uterus (women only)

Last Menstrual Period _____
 Length of Menses _____
 Regular cycle

 Irregular cycle

 Early (less than 28 days)

 Late (more than 28 days)

 Skip cycle

 Flow (heavy/ moderate/ light)

 Cramps (mild/ mod/ severe)

 Clotting/ Spotting

 Headache side of head

 Other _____

Ovaries (women only)

Sex Drive Flat/ Low/ Normal/ High

 Low Abdominal Puffiness

 Fluid Retention Face/ Hands/ Feet

 mood swings/irritable/depression

 Tired during cycle

 Ovarian pain

 Breast Tender around cycle

 Acne around cycle (pre/mid/post)

 Birth Control Pill/ Patch

 Menopausal Natural /Surgical

 Hot Flashes

 Facial Hair growth

 Dark Nipple Hair

 Hair growing up towards belly button

 Skin Crawling

 Breast discharge

 Breasts shrinking

 Breast Feeding

 Breast Surgery

 Other _____

Vagina (women only)

Burn

 Itch

 Dry

 Discharge-clear white yellow green brown

 Pain with Intercourse

 Other _____

Testes (men only)

Sex Drive Flat/ Low/ Normal/ High

 Decreased morning erections

 Decreased fullness erections

 Inability to concentrate

 Episodes of depression

 Decreased physical stamina

 Sweating Attacks

 More emotional than past

 Unexplained weight gain

 Other _____

Sleep

Quality (poor/fair/good/great)

 Hours in bed

 Hours asleep

 Interrupted _____ per night

 Awaken Suddenly (Jolt)

 Other _____

Emotions

Stress

 Sad

 Grief

 Depression

 Moodiness

 Frustrated

 Irritable

 Angry

 Worrisome

 Nervous

 Anxiety

 Panic

 Cry

 Fear

 Shame

 Guilt

 Other _____

Brain

Forget Names

 Forget Numbers

 Forget Words

 Forget Actions

 Difficulty Focus/ Concentrating

 Other _____

Exercise

Cardiovascular _____ times/ week

 Weight Train _____ times/per week

 Other _____

Glycemic Management Pillar #2**Pancreas**

Crave Sweets

 Irritable when skip meals

 Light headed skip meals

 Eating relieves fatigue

 Bouts of blurred vision

 Fatigue after meals

 Frequent Urination

 Increased Thirst

 Difficulty losing weight

 Other _____

Appetite / Diet

Appetite (Low, Norm, High)

 Eat Animal Protein _____/per day

 Eat Starch (pasta/bread/potatoes/rice)

 Eat Sweets (cakes, cookies, candy)

 Eat Chocolate _____/per week

 Eat Spicy Foods _____/per week

 Eat Ice Cream _____/per week

 Coffee _____ cups/ week

 Caffeinated Tea _____ cups/week

 Juice _____ per week

 Soda _____ per week

 Beer _____ per week

 Wine _____ per week

 Liquor _____ per week

 Avoid Artificial Sweeteners _____ %

 Avoid Trans Fats _____ %

 Avoid Food Allergens _____ %

 Special Diet? _____

Bioterrain/ Mineral Pillar #3

Twitching around eyes

 Difficulty falling asleep

 Restlessness

 Don't Remember Dreams

 Nails spots or weakness

 Air Hunger/ frequent sighs

 Cramps (legs/feet/arms/hands)

 Aches (legs/feet/arms/hands)

 Restless (legs/feet/arms/hands)

 Frequent Thirst

 Shallow rapid breathing

 Poor muscle endurance

 Swelling in ankles and wrists

 Uterine cramps women

 Urination leakage

 Other _____

Inflammatory / Immune Pillar #4**Eyes**

Burn / Red/ Dry

 Sad

 Eye Film/ Crust in morning

 Floaters

 Style

 Itchy Eyes

 Eye Ache

 Vision blurry

 Tired

 Spots

 Puffy

 Dark Circles

 Other _____

Ears

Ear Noise (Ring/Hiss/Pound)

 Ear Plugged

 Ear Popping

 Ear Ache / Infections

 Ears Itch internally

 Ear Drainage

 Hearing Loss

 Excessive Ear Wax

 Dizziness/ Vertigo

 Other _____

Sinus

Frontal headache

 Sinus dry

 Sinus drain

 Sinus stuffy or pressure

 Sneezes frequent

 Smell / Taste Loss

 Post nasal drip

 mucous: clear/white/yellow/green/brown

 Other _____

Lungs

Chest Congestion

 Pain on Breastbone

 Shortness of Breath upon exertion

 Frequent Sighs

 Wheezing

 Asthma

 Emphysema

 Bronchitis

 Other _____

Mouth/ Throat/ Immune

Blisters

 Canker Sore

 Bad Breath

 Dry Mouth

 Bleeding gums

 Receding gums

 Teeth Health Problems

 Swelling of Glands

 Cough (dry/ productive)

 Sore Throat

 Hoarseness

 Fever

 Frequent Colds/ Flu

 Environmental Allergies

 Nail fungus (mild/mod/severe)

 Nightmares

 Other _____

Bladder

Urinate _____ times per day-awake

 Awake from sleep to urinate _____ times

 Urination urgency

 Burning /Pain urination

 Cloudy urine

 Odor urine

 Spasm urinate

 Urinary Tract Infection

 Kidney Pain or Infections

 Other _____

Skin

Skin Rash

 Acne

 Itchy Skin

 Cellulite

 Other _____

Breasts (women only)

Breast fibrosis

 Breast Lumps

 Other _____

Prostate (Men only)

Urination difficulty

 Frequent urination

 Urination Burn / Achiness / Pain

 Urination Dribbling /Emission/ Swelling

 Pain inside of legs or heels

 Leg twitching at night

 Headache side of head

 Other _____

Cardiovascular Pillar #5

Chest Tension/ Tight/ Pressure

 Chest Heaviness

 Chest Heart Pain

 Heart Palpitations-Skip/Flutter

 Heart Racing

 Heart Slowing down

 Constant Shortness of Breath

 Sleep Apnea

 Mitral Valve Prolapse

 Murmur

 Bruise easily

 Other _____

Digestion Pillar #6**Stomach**

Heartburn

 Indigestion

 Stomach Aches

 Stomach Cramps

 Nausea/ Queasy

 Bloat after Eat

 Gas/ Flatulence

 Belching

 Ulcer

 Hiatal Hernia

 Other _____

Liver/ Gallbladder

Headaches at base of skull

 Greasy high fat foods cause distress

 Difficulty losing weight

 Dry or Itchy Skin

 Patches skin look different

 Yellow cast to eyes

 Stool color clay colored

 History of gallbladder attacks

 Excessively foul smelling sweat

 Hormonal imbalances

 Difficulty Swallowing

 Wake up between 11pm - 3am

 Other _____

Hemorrhoids

Swollen/ Distended / Bloody Anus

 Burning Anus

 Itchy/ Stinging Anus

 Achy Anus

 Other _____

**List Your Primary Concerns
in order of importance to you:**

1) _____
 2) _____
 3) _____

Bowels

Bowel Movements _____ Per day

 Regular

 Incomplete

 Skip days _____ per (week/month)

 Sluggish bowels every _____ days

 Cramps in Abdomen

 Taking Laxatives

 Using Suppositories

 Enemas

 Colonics

 Pain with Bowel Movements

 Irritable Bowel Syndrome

 Chrons

 Colitis

 Other _____

Fecal Consistency

Color feces light or dark _____

 Normal

 Soft

 Hard

 Pebbles

 Dry

 Ribbon-like

 Bulky

 Mucous

 Diarrhea

 Constipation

 Other _____

Cellular Vitality Pillar #7

Fatigue constant

 Dehydrated

 Slow to Heal

 Low Stamina

 Sluggish Memory

 Inability to achieve lean body

 Other _____

**PAIN/ STIFFNESS/ SWELLING/
ACHE/ NUMBNESS/ TINGLING**

Head

 Facial

 Neck

 Trapezius

 Upper Back

 Shoulders

 Arms

 Elbows

 Wrist

 Hand

 Mid Back

 Low Back

 Sacral Iliac

 Hips

 Buttocks

 Legs

 Knees

 Ankles

 Feet

 Other _____

For Doctor's Use

Luna Fingernails Rt 1 2 3 4 5 Lt 1 2 3 4 5

 Splinter Hemorrhages

 Ear Creases (Rt/ Lt) (mild/mod/severe)

 Cherry Hemangioma

 Frenulum Cyst

 Color Tongue _____

 Coated Tongue (mild/mod/severe)

 Cracks in Tongue-midline/ all over

 Swollen Tongue

 Dark Veins under Tongue

 Allergy Patches Tongue

 Red Spots Tongue

 Geographic Tongue

 Height _____
 Weight _____ (+/- _____ lbs.)
 Overall (+/- _____) Desired Wt _____
 Pulse _____ BP: (_____/_____)
 saliva pH _____ Urine pH _____
 Allergies _____
 Current Meds: _____

NUTRITION CONSULTING INFORMED CONSENT

I hereby request and consent to nutritional care/consulting on me (or on the client named below, for whom I am legally responsible) provided by Chronic Conditions Center of Greensboro and staff.

I understand and am informed that the nutrition consultations may not be made by medical physicians and do not dispense medical advice, diagnose illness or disease, offer prescription drugs, surgery, or other conventional treatments.

I understand and am informed that the nutrition consultations offer nutritional evaluations, nutritional supplementation, and lifestyle consultation along with various methods of testing. I further understand and am informed that the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only provided by the health practitioner and/or his/her staff pertain to the whole-body concept of nutrition and does not relate in the context of any specific ailment or condition.

I understand and am informed that methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor my progress in achieving my goals. I further understand that any nutritional recommendations are supportive in nature allowing the body to return to improved health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment. Products are only refundable if they are unopened and in original condition, including not past their expiration date.

I understand and am informed that the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that have been recommended are traditionally considered safe in the practice of nutrition, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner and/or his/her staff if I am or become pregnant.

I will also inform the health practitioner and/or his/her staff if I experience any gastrointestinal upset (including but not limited to nausea, gas, stomachache, vomiting), allergic reactions (including but not limited to hives, rashes, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients recommended by the health practitioner and/or his/her staff.

I have had an opportunity to ask questions about its content, and by signing below I agree to the above-named services. I intend this consent to cover the entire course of nutritional care/consulting.

I, _____ have read, or have had read to me, the above consent.
(Print Name)

(Signature)

(Date)

Consent to evaluate and treat a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above consent and hereby grant permission for my child to receive care.

(Signature)

(Date)

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, _____ have read and fully understand the above statements.
(Print Name)

(Signature)

(Date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

(Doctor's Signature)

(Date)

OFFICE POLICIES

*****Please read all these thoroughly before signing*****

1. PAYMENT IS DUE IN FULL WHEN SERVICES ARE RENDERED. PRE-PAYMENTS AND PAYMENT PLANS MAY BE ACCEPTED ON A CASE-BY-CASE BASIS. A general schedule of services and fees are available by inquiring at the front desk. Payments can be made by cash, check, debit card, credit card, health savings, or flex spending accounts.
2. In the event that a patient's account is delinquent, an overdue notice will be sent his/her address on file. If payment is not received within 30 days of the notice date, a 1.5% per month service charge will be incurred until paid in full.
3. There will be an additional \$25 fee for returned or NSF checks.
4. This office is not in network with any insurance company, nor will we submit any insurance claim for you. You may ask for a Superbill to submit to your insurance for re-imbursement. If you have an HSA account, most often you may use your flex spending card to pay for your services.
5. It is not this office's obligation to enter into a dispute with an insurance company concerning payment.
6. If 6 months or more lapse between a patient's treatments, the next appointment scheduled will automatically be a re-examination, which incurs an additional fee.
7. Nutrition consultations, exercise consults or supplement charges are due at the time of service. These are cash services, not covered by any insurance or third-party payers.
8. Laboratory testing (varies by company) may or may not be covered by your insurance.
9. Medicare covers spinal adjustments only in an acute injury and does not cover any exams, x-rays, re-exams, modalities, extremity adjustments, supports or supplements. If you receive any of these non-covered services or supplements, it is your responsibility to pay the complete cost at the time received. Medicare also does not cover Maintenance or Wellness care. If you choose these services, these are paid out of pocket at the Medicare rate.
10. Our office routinely makes video and audio recordings for security, quality assurance, and training purposes. Recording devices are placed throughout the office. By entering our office, you are consenting to be video recorded, and audio recorded. I hereby give my permission to be recorded and for those recordings to be used for security, quality assurance, and training purposes.

Patient's Printed Name: _____ Date: _____

Signature: _____



CHRONIC CONDITIONS

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Patient Missed Appointment Policy

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results. If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in your life so that this can occur.
2. Our office strives to run on time as much as possible. If you are more than 5 minutes late for an appointment, you may be asked to reschedule.
3. If you become ill, there are instances where we want you to come in, because your treatment will help you recover, so please ask the front desk about your illness and if you should come in for treatment.
4. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment.
5. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change an appointment.
6. If you choose to not finish your entire treatment regimen for the day, they will be counted as completed. The only exception that is made is in the event that the office is not able to accommodate your therapies in an adequate time frame during the scheduled therapy time.
7. Service charges for missing an appointment or cancelling without 24 hour notice are as follows:
15 minute appointment \$45
30 minute appointment \$60

Treatment Packages:

1 warning and then 1 treatment will be deducted per missed or late cancel appointment

*Note: Text reminders are made the day before each patient's appointment. These texts are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a confirmation text does NOT validate a missed appointment.

I have read and understand the above policies.

Patient's Name: _____ Date: _____

Signature: _____

Witness: _____ Date: _____

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chronic Conditions Center of Greensboro or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the complete Notice of Privacy Practices for more description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. 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.

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.

- ☐ 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 or other operational purposes.
- ☐ Your health care practitioner 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.

Requesting a Restriction on the Use or Disclosure of Your Information

- ☐ You may request a restriction on the use or disclosure of your Protected Health Information at any time.
- ☐ This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- ☐ If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By my signature below I give my permission to use and disclose my health information in the ways listed above.

Patient's Name (PRINT): _____

Date: _____

Signature: _____

Witness Signature: _____

Date: _____

PHI (Protected Health Information) Disclosure Agreement

Patient Name: _____ Date of Birth: _____

Chronic Conditions Center is authorized to release my protected health information in the following manner and/or the selected person(s):

Please check all ways you would like to receive information:

Email	Text	Voice Mail
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please List any individuals that you authorize your PHI to be shared with:

_____	_____	_____
Name	Number	Relation
_____	_____	_____
Name	Number	Relation

I authorize the above individuals to receive the following types of information:

Medical Financial

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Patient Rights:

-I have the right to revoke this authorization at any time

-Revocation is not effective in cases where the information has already been disclosed

-Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law

Signature of Patient

Date