

# NORTHERN CHIROPRACTIC, P.C.

## PERSONAL

*Thank You For Choosing Us As Your Option For Health*

## GUARANTOR

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security# \_\_\_\_\_  
 Gender ☐ Male ☐ Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Cell # \_\_\_\_\_  
 Secondary Contact # \_\_\_\_\_ work / cell / hm  
 May we text appt. reminders? Y N Phone \_\_\_\_\_  
 Email \_\_\_\_\_  
 Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed  
 Spouse \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
 Relation to Contact \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to us?

### How did you choose our clinic?

- ☐ Echo Magazine ☐ Google  
☐ Good Deal Magazine ☐ Insurance PPO \_\_\_\_\_  
☐ Office Sign ☐ Location  
☐ Website ☐ Health Care Provider/Doctor  
☐ Yelp ☐ Other \_\_\_\_\_

## CASE

Were you in an Auto Accident? \_\_\_\_\_ Injury Date: \_\_\_\_\_  
 Were you in a Work related Injury? \_\_\_\_\_ Injury Date: \_\_\_\_\_  
 Will you be utilizing medical benefits? \_\_\_\_\_

NO Insurance	Medicaid	Auto Med-Pay
Insurance	Medicare	Work Comp Ins.

Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Department \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

### PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED

### PAYMENT METHOD FOR PATIENT'S PORTION WILL BE:

- ☐ Cash ☐ Check ☐ Credit Card  
☐ Check Debit ☐ Credit Balance

Policy Holder (PH) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security# \_\_\_\_\_  
 Gender ☐ Male ☐ Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Employer (PH) \_\_\_\_\_  
 Employer Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance

Call Benefits @ \_\_\_\_\_  
 Contact \_\_\_\_\_  
 Group Number \_\_\_\_\_  
 ID/Claim # \_\_\_\_\_

### 2nd Insurance

### Patient Is:

- ☐ Self ☐ Spouse ☐ Child ☐ 3rd Party ☐ Other \_\_\_\_\_

## CONSENT TO TREAT MINOR

I authorize Dr. Gregory Culbert to perform chiropractic care on my child \_\_\_\_\_

X \_\_\_\_\_  
 Parent/Guardian's Signature Date

## AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to:

## NORTHERN CHIROPRACTIC

of the "Health Benefits", "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.

X \_\_\_\_\_  
 Patient/Guarantor's Signature Date

## GENTLE, EFFECTIVE HEALTHCARE FOR ALL AGES AND LIFESTYLES

Gregory M. Culbert, D.C. DABCO, Chiropractic Orthopedist  
 11723 Old Glenn Highway • Eagle River, AK 99577 • Phone (907) 696-4878 • Fax (907) 696-4674

Fractured/Broken Bones? When? Where? \_\_\_\_\_

Major Accidents or Falls? When? \_\_\_\_\_

Prior Surgeries? When? \_\_\_\_\_

Medications/Vitamins? Today? \_\_\_\_\_

Prior Diagnosis/Disease/Illness? When? \_\_\_\_\_

Allergies? \_\_\_\_\_

Habits? \_\_\_\_\_

Medical doctor's name: \_\_\_\_\_

Are you under a doctor's care now? Why? \_\_\_\_\_

Is this your first visit to a Chiropractor? Yes No

Name/Address of former Chiropractor: \_\_\_\_\_

(Women) Are you pregnant or trying? Yes No    Nursing? Yes No    Taking birth control pills? Yes No

What type of exercise do you perform on a regular basis? \_\_\_\_\_

What do your daily work habits include? (sitting, standing, light labor, heavy labor, computer work): \_\_\_\_\_

Has any member of your family had any of the following? List Relationship      Arthritis? Type? \_\_\_\_\_  
 High Blood Pressure? \_\_\_\_\_ Diabetes? \_\_\_\_\_ Cancer? Type? \_\_\_\_\_  
 Heart Problems? \_\_\_\_\_ Back or Neck Problems? \_\_\_\_\_ Other? \_\_\_\_\_

Purpose of this chiropractic appointment:    ☐ Examination    ☐ Emergency    ☐ Consultation

Date and time of injury: \_\_\_\_\_ Location of injury: \_\_\_\_\_

What activity were you doing when injured? \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_ Symptoms developed from: \_\_\_\_\_

\_\_\_\_\_

Were you hospitalized?    Yes    No    Where? \_\_\_\_\_

Major complaints: \_\_\_\_\_

\_\_\_\_\_

Have you had this complaint before? Explain: \_\_\_\_\_

Doctors seen for this ailment: \_\_\_\_\_

Type of Doctor: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

[illegible]

# Oswestry Low Back Pain Scale

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

## Section 1 – Pain Intensity

- 0. The pain comes and goes and is very mild.
- 1. The pain is mild and does not vary much.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain comes and goes and is severe.
- 5. The pain is severe and does not vary much.

## Section 2 – Personal Care (Washing, Dressing, ect.)

- 0. I would not have to change my way of washing or dressing in order to avoid pain.
- 1. I do not normally change my way of washing or dressing even though it causes some pain.
- 2. Washing and dressing increase the pain but I manage not to change my way of doing it.
- 3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- 4. Because of the pain I am unable to do some washing and dressing without help.
- 5. Because of the pain I am unable to do any washing and dressing without help.

## Section 3 – Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it gives extra pain.
- 2. Pain prevents me lifting heavy weights off the floor.
- 3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- 4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 5. I can only lift very light weights at most.

## Section 4 – Walking

- 0. I have no pain on walking.
- 1. I have some pain on walking but it does not increase with distance.
- 2. I cannot walk more than 1 mile without increasing pain.
- 3. I cannot walk more than ½ mile without increasing pain.
- 4. I cannot walk more than ¼ mile without increasing pain.
- 5. I cannot walk at all without increasing pain.

## Section 5 – Sitting

- 0. I can sit in any chair as long as I like.
- 1. I can sit only in my favorite chair as long as I like.
- 2. Pain prevents me from sitting more than 1 hour.
- 3. Pain prevents me from sitting more than ½ hour.
- 4. Pain prevents me from sitting more than 10 minutes.
- 5. I avoid sitting because it increases pain immediately.

## Section 6 – Standing

- 0. I can stand as long as I want without pain.
- 1. I have some pain on standing but it does not increase with time.
- 2. I cannot stand for longer than 1 hour without increasing pain.
- 3. I cannot stand for longer than ½ hour without increasing pain.
- 4. I cannot stand for longer than 10 minutes without increasing pain.
- 5. I avoid standing because it increases the pain immediately.

## Section 7 – Sleeping

- 0. I get no pain in bed.
- 1. I get pain in bed but it does not prevent me from sleeping well.
- 2. Because of pain my normal sleep is reduced by less than one-quarter.
- 3. Because of my pain my normal sleep is reduced by less than one-half.
- 4. Because of my pain my normal sleep is reduced by less than three-quarters.
- 5. Pain prevents me from sleeping at all.

## Section 8 – Social Life

- 0. My social life is normal and gives me no pain.
- 1. My social life is normal but it increases the degree of pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- 3. Pain has restricted my social life and I do not go out very often.
- 4. Pain has restricted my social life to my home.
- 5. I have hardly any social life because of the pain.

## Section 9 - Traveling

- 0. I get no pain when traveling
- 1. I get some pain when traveling but none of my usual forms of travel make it any worse.
- 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- 3. I get extra pain while traveling which compels me to seek alternate forms of travel.
- 4. Pain restricts me to travel short necessary journeys under ½ hour.
- 5. Pain restricts all forms of travel.

## Section 10 – Changing Degree of Pain

- 0. My pain is rapidly getting better.
- 1. My pain fluctuates but is definitely getting better.
- 2. My pain seems to be getting better but improvement is slow.
- 3. My pain is neither getting better or worse.
- 4. My pain is gradually worsening.
- 5. My pain is rapidly worsening.

**TOTAL** \_\_\_\_\_

# Neck Disability Index

Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** Please circle the **ONE NUMBER** in each section which most closely describes your problem.

## Section 1 – Pain Intensity

- 0. I have no pain at the moment.
- 1. The pain is mild at the moment.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain is severe but comes and goes.
- 5. The pain is severe and does not vary much.

## Section 2 – Personal Care

- 0. I can look after myself without causing extra pain.
- 1. I can look after myself but it causes extra pain.
- 2. It is painful to look after myself and I am slow and careful.
- 3. I need some help, but manage most of my personal care.
- 4. I need help every day in most aspects of self-care.
- 5. I do not get dressed, I wash with difficulty and stay in bed.

## Section 3 – Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights but it causes extra pain.
- 2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned.
- 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4. I can lift very light weights.
- 5. I cannot lift or carry anything at all.

## Section 4 – Reading

- 0. I can read as much as I want to with no pain in my neck.
- 1. I can read as much as I want with slight pain in my neck.
- 2. I can read as much as I want with moderate neck pain.
- 3. I cannot read as much as I want because of moderate pain in my neck.
- 4. I cannot read as much as I want because of severe pain in my neck.
- 5. I cannot read at all.

## Section 5 – Headache

- 0. I have no headaches at all.
- 1. I have slight headaches which come infrequently.
- 2. I have moderate headaches which come infrequently.
- 3. I have moderate headaches which come frequently.
- 4. I have severe headaches which come frequently.
- 5. I have headaches almost all the time.

## Section 6 – Concentration

- 0. I can concentrate fully when I want to with no difficulty.
- 1. I can concentrate fully when I want to with slight difficulty.
- 2. I have a fair degree of difficulty in concentrating when I want to.
- 3. I have a lot of difficulty concentrating when I want to.
- 4. I have a great deal of difficulty in concentrating when I want to.
- 5. I cannot concentrate at all.

## Section 7 – Work

- 0. I can do as much work as I want to.
- 1. I can only do my usual work, but no more.
- 2. I can do most of my usual work, but no more.
- 3. I cannot do my usual work.
- 4. I can hardly do any work at all.
- 5. I cannot do any work at all.

## Section 8 – Driving

- 0. I can drive my car without neck pain.
- 1. I can drive my car as long as I want with slight pain in my neck.
- 2. I can drive my car as long as I want with moderate pain in my neck.
- 3. I cannot drive my car as long as I want because of moderate pain in my neck.
- 4. I can hardly drive my car at all because of severe pain in my neck.
- 5. I cannot drive my car at all.

## Section 9 – Sleeping

- 0. I have no trouble sleeping.
- 1. My sleep is slightly disturbed (less than 1 hour sleepless).
- 2. My sleep is mildly disturbed (1-2 hours sleepless).
- 3. My sleep is moderately disturbed (2-3 hours sleepless).
- 4. My sleep is greatly disturbed (3-5 hours sleepless).
- 5. My sleep is completely disturbed (5-7 hours sleepless).

## Section 10 – Recreation

- 0. I am able to engage in all recreational activities with no pain in my neck.
- 1. I am able to engage in all recreational activities with some pain in my neck.
- 2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
- 3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- 4. I can hardly do any recreational activities due to pain in my neck.
- 5. I cannot do any recreational activities at all.

**TOTAL** \_\_\_\_\_

# Daily Living Limitations

Name \_\_\_\_\_ Date \_\_\_\_\_

- Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying Down _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving car _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grocery shopping _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching Overhead _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting sleep _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What percentage do you feel your pain has improved since your last evaluation? \_\_\_\_\_

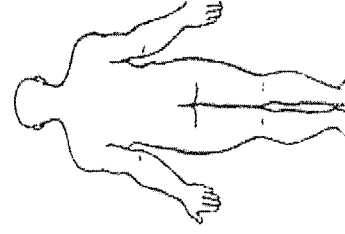
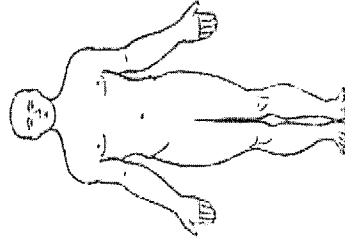
Label area(s) of discomfort using arrows, and other descriptions as needed:

Pain           XXX

Numb           NNN

Burn           BBB

Tingly         TTT



Comments/Descriptions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## FINANCIAL AGREEMENT

### INSURANCE

As a courtesy to our patients, Northern Chiropractic will bill your health insurance. Also as a courtesy we will verify benefits with your insurance company; this does not guarantee payment for services and is highly recommended that you double check your own benefits with your insurance company either in your plan booklet, online or by calling your insurance company. To process insurance claims quicker, please call your insurance company to answer any questionnaires. Even though an insurance claim is filed, the patient will receive a statement each month indicating the amount owed. This office cannot accept responsibility for collecting your insurance claim, claims denied for medical necessity or for negotiating a settlement on a disputed claim. We expect payment of the portion not covered by your insurance company. All co-pays and fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA, MASTERCARD and DISCOVER. If needed, financial arrangements are available. Financial arrangements must be discussed and approved.

### VA

Northern Chiropractic accepts VA authorizations/referrals. It is the job of the patient to initiate the referral from the VA. As a provider we can request date extensions on already established authorizations, but we cannot request additional visits beyond 26 visits; additional visits must be requested by the veteran. We are unable to schedule additional visits within our office until the additional visits are approved. If you choose to schedule additional visits with the chiropractor or massage therapists you are financially responsible for those visits if they go unpaid by the VA.

### NON-INSURED/CASH

All fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA and MASTERCARD. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

### WORKERS' COMPENSATION

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware you were injured on the job and you have completed the necessary required paperwork. We will bill your Workers' Compensation Carrier. However, should a controversion arise, please be advised you are responsible for any outstanding amounts. If needed, Northern Chiropractic will assist you with any claims filed as much as possible.

### MEDICARE

It is Federal Law that we charge for all services provided. Medicare does not pay for X-rays, examinations, physical therapy, maintenance care, supplements or supplies when ordered and delivered by a chiropractic physician. There may be other non-covered services you will be responsible for. If you have a supplemental insurance policy that covers chiropractic we will bill them for you if Medicare does not. All co-pays and fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA and MASTERCARD. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

### MEDICAID

Dr. Culbert is a participating Medicaid provider and will bill covered services as a courtesy as long as we have your current information on file, and you provide us with a copy of your monthly eligibility coupon or Denali Kid Care card. All co-pays and fees are due at the time of service. Examinations, any x-rays and adjustments NOT related to the spine and any physical therapy modalities are NOT covered by Medicaid and are the patient/guardian's financial responsibility. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA, MASTERCARD and DISCOVER. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

### IT MUST BE UNDERSTOOD

1. Northern Chiropractic **DOES NOT** guarantee that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. Northern Chiropractic will not enter into a dispute with an insurance company for a reimbursement or the amount of reimbursement. The contract is between the patient and the insurance company, therefore, it is the patient's responsibility to see to it the insurance company pays its portion.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Northern Chiropractic, PC  
11723 Old Glenn Hwy., Ste 101  
Eagle River, AK 99577

# Electronic Health Records Intake Form

*In compliance with Medicare requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: \_\_/\_\_/\_\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

## Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### The nature of the chiropractic adjustment.

The primary treatment that I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

### Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to some or all of the following procedures:

- |  |   |                                      |   |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Spinal manipulative therapy | <input type="checkbox"/> Palpation            | <input type="checkbox"/> Vital Signs | <input type="checkbox"/> Range of motion testing  |
| <input type="checkbox"/> Orthopedic testing          | <input type="checkbox"/> Postural analysis    | <input type="checkbox"/> Ultrasound  | <input type="checkbox"/> Basic neurological tests |
| <input type="checkbox"/> Muscle strength testing     | <input type="checkbox"/> Radiographic studies | <input type="checkbox"/> EMS         | <input type="checkbox"/> Hot/cold therapy         |
| <input type="checkbox"/> Deep tissue massage         | <input type="checkbox"/> Manual therapy       |                                      |   |

### The material risks inherent in chiropractic adjustment.

As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would not otherwise come to my attention, it is your responsibility to inform me.

### The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

### The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

### The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.  
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Gregory Culbert and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature of Parent or Guardian (if a minor): \_\_\_\_\_



NORTHERN CHIROPRACTIC, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

I hereby acknowledge that I have received a copy of NORTHERN CHIROPRACTIC, PC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor  
☐ Court appointed guardian  
☐ Executor or administrator of decedent's estate  
☐ Power of Attorney

-----  
FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

\_\_\_\_\_ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign  
☐ Emergency situation prevented us from obtaining acknowledgement at this time  
(will attempt again at a later date)  
☐ Communication barriers prohibited obtaining acknowledgement (Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ Other (Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# NORTHERN CHIROPRACTIC, PC

## Authorization for Use and Disclosure of Protected Health Information

I hereby authorize \_\_\_\_\_ to use and/or disclose my protected health information as described below to:

(name and address of recipient) Northern Chiropractic, PC  
11723 Old Glenn Highway, Suite 101, Eagle River, AK 99577

for the following purposes: (describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)  
\_\_\_\_\_  
\_\_\_\_\_

I understand that:

- 1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying NORTHERN CHIROPRACTIC, PC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) NORTHERN CHIROPRACTIC, PC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

### Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

### Type of Information to Be Disclosed

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Most Recent 5 Year History             | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Office Chart Notes    | <input type="checkbox"/> All Hospital Records                   | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Billing Statements    | <input type="checkbox"/> Transcribed Hospital Reports           |  |
| <input type="checkbox"/> Dental Records        | <input type="checkbox"/> History and Physical Exam              | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Laboratory Reports    | <input type="checkbox"/> Emergency and Urgent Care Records      |  |
| <input type="checkbox"/> Pathology Reports     | <input type="checkbox"/> Medical Records for Continuity of Care |  |
| <input type="checkbox"/> Consultation          | <input type="checkbox"/> Diagnostic Imaging Reports             |  |
| <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Emergency Room Reports                 |  |

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection      ☐ Drug/Alcohol abuse      ☐ Genetic Testing

### Expiration:

This authorization will expire 180 days from the date of signing or (insert date) \_\_\_\_\_.

Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

Signature of Patient or Legal Representative \*

Date \*

Printed Name of Patient's Representative (if applicable) \*

### Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor  
☐ Court appointed guardian  
☐ Executor or administrator of decedent's estate  
☐ Power of Attorney

Signature of Witness

Date