CORNERSTONE FAMILY CHIROPRACTIC, INC.
PH: (774) 847-7474
INFO@CORNERSTONEFAMCHIRO.COM
15 NORTH MAIN STREET, STE B-5
BELLINGHAM, MA 02019

"What should I expect in today's exam?"

Our Objective:

The objective of our practice is to improve the health and well-being of the spine and nervous system to help you get back to your life. We accomplish this by locating, analyzing and correcting vertebral subluxation complexes (spinal misalignments with aberrant motion affecting proper functioning of the nervous system). The vertebral subluxation complex creates damage to the vertebrae resulting in disc, joint, muscle and nerve injury.

Subluxations impact your daily life experience; reducing your emotional, physical and intellectual well-being. The longer these subluxations remain uncorrected, the more damage occurs and the longer it takes to correct. Even newborns can experience spinal damage from the birth process.

Our vision is to assist individuals and families in regaining and maintaining their health throughout their life.

Today's Visit

After completing all necessary paperwork, the doctor will conduct a thorough health history, consultation, and examination to see if you or your child are/is a candidate for Chiropractic care. In addition, the doctor may conduct several specialized exams depending on the case. If the doctor feels that you/your child may benefit from care, an x-ray study may be recommended to aid in assessment of spinal health and with the prognosis for treatment.

Following the completion of your examination, you will be asked to schedule a follow up appointment where the doctor will review findings of the evaluation with you. It is our intention to exceed your expectations and provide you with the ***highest quality of service*** and Chiropractic care.

Insurance

We are an ***out-of-network provider*** for all insurance networks. If your insurance plan has "out-of-network" benefits, we will be happy to provide you with any appropriate paperwork to aid with your reimbursements. This model allows us to offer ***high quality care*** for your family at an ***affordable*** price.

We feel strongly that patient care and your family's health should be based on clinical need and not on ***insurance limitations****.*

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HEALTH HISTORY FORM (ADULT)

Please fill out this form as completely and accurately as possible.

Today's Date_____

PERSONAL DATA

Name_____Age_____Date of Birth_____

Parents' Names (*if you are under 18*)_____

Home Address_____City_____State_____Zip_____

Home Phone (____)_____Work Phone (____)_____

Cell Phone (____)_____ Cell provider _____ (For text reminders)

Email Address_____

Occupation_____Employer_____

Marital Status ☐ S ☐ M ☐ D ☐ W Spouse's/Partner's Name:_____

Names and Ages of Children_____

Whom may we thank for referring you to our office?_____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Cornerstone Family Chiropractic, Inc. can address for you?

☐ Wellness & Spinal Vertebral Subluxation Evaluation

☐Other:_____

Are these concerns affecting your quality of life? (*Please circle "Y" or "N".*)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/Sports:	Y	N	Eating:	Y	N	Other:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ☐ Y ☐ N Name of D.C._____

Under care for how long? ☐_____days ☐_____weeks ☐_____months ☐_____years

Date of last visit:_____ Why did you stop?_____

How was your experience?_____

Permission for Xrays:
If an X-Ray study is recommended, your signature is required (below) for your consent. ***Women, by signing below you verify that you are <u>not pregnant</u>.*** *(If any question that you are pregnant, please notify the doctor.)*
Signature:_____ Date:_____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and nutritional/chemical stressors, common to our contemporary lifestyles and environments, can result in dysfunctional areas in the spinal column and interferences to neurological communication. This is called ***Vertebral Subluxation Complexes****. The Chiropractic evaluation is specifically designed to detect Vertebral Subluxation Complexes in all phases of their progression.*
Many common symptoms and conditions are caused by the interference on the nerve system and by imbalances of the body due to our environmental stressors. Please place an (X) on conditions that you are currently suffering from and an (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal Problems

__Headache
__Migraine Headache
__Neck Pain (R / L)
__Shoulder Pain (R / L)
__Numbness/Tingling
in arms, or hands (R / L)
__Carpal Tunnel Syndrome
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of Memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficulty Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid-Back Pain / Stiffness
__Pain with cough/Bowel Mvmt
__Hip Pain
__Low Back Pain/Stiffness
__Sciatica
__Numbness/Tingling in
legs or feet (R / L)
__Muscle Tightness
__Trouble Sleeping

OFFICE POLICIES

"I clearly understand and agree that all services rendered for treatment are charged directly to me and that I am personally responsible for the payment of the same in a timely manner. I will not hold any doctor, employed by Cornerstone Family Chiropractic, Inc., responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered to date will become immediately due and payable. In the event I fail to timely pay any fees for professional services rendered, I understand that I will be responsible for any additional costs and expenses, including but not limited to collection and/or legal costs incurred in order to secure payment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policy holder. I understand that Cornerstone Family Chiropractic, Inc. will willingly prepare any necessary reports and forms to assist me in collecting from the insurance company.

I acknowledge that some patients may experience mild discomfort due to examination procedures. I hereby authorize the Doctor to examine and diagnose my condition, as he or she deems appropriate."

(By signing below, I hereby acknowledge and agree to abide by the office policies as provided above by Cornerstone Family Chiropractic, Inc.)

DATE:_____

SIGNATURE:_____

PRINTED NAME:_____

Notice of Privacy Practices

We are concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policy and procedures. We encourage you to read this document for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal information, we would be happy to address them.

"I have received a copy of the HIPAA for Cornerstone Family Chiropractic, Inc."

_____ _____ /_____ /_____

Signature Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it.

Adjustment – An adjustment is the specific application of forces that facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. *Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom.* Our only method is specific **adjustments** to correct vertebral subluxations.

"I understand that I have the right to have all of my questions pertaining to the purpose of chiropractic care answered to my complete satisfaction prior to my first adjustment. "

_____ _____ /_____ /_____

Signature **Date**

CONSENT TO TREAT A MINOR
(CHILD UNDER 18)

"I hereby request and authorize Dr. Timothy J. Murzycki of Cornerstone Family Chiropractic, Inc. to perform diagnostic tests and render chiropractic adjustments and other treatments as Dr. Murzycki deems appropriate to my child,_____ (hereinafter "Patient").
(PRINT NAME OF MINOR)

This authorization also extends to any and all other doctors and trained office staff employed by Cornerstone Family Chiropractic, Inc. and is intended to include radiographic examination at the discretion of the doctor. As of this date, I represent that I have the legal right to select and authorize health care services for the Patient.

(If applicable) Under the terms and conditions of my divorce, separation or legal authorization, the consent of my spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I shall immediately notify Cornerstone Family Chiropractic, Inc."

SIGNATURE: _____ ***DATE***:_____

PRINTED NAME: _____ ***RELATIONSHIP TO PATIENT***:_____