ZIMMERMAN FAMILY CHIROPRACTIC

Dr. Kiley Zimmerman
7504 ½ University Avenue
Cedar Falls, IA 50613
319.277.1679
ucdocz@gmail.com

Please fill out the following
Please Print and Circle where Appropriate

Today's Date: _____ Referred by: _____

Name: _____ E-mail Address: _____
Home Phone: _____ Cell Phone: _____ Office Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Your Employer: _____ Occupation: _____ Years on Job: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Your Work Hours: _____ Your SS#(Optional): _____

Medical Doctor: _____ Phone: _____
Dentist: _____ Phone: _____

Do You Have Medicare? Yes No Medicaid? Yes No Medicare #: _____

Name of Spouse or Parent: _____ Phone: _____
In CASE OF Emergency Contact: _____ Phone: _____

List The Major Complaints That Bring You To Our Office:

_____
_____
_____

Do any of these conditions interrupt? Career Family Social Life Ability to Exercise Sleep

Is Your Condition Due To An Accident? Yes No Date of Accident: _____
Type of Accident? Auto Work/Job At Home Other: _____

What results do you want for yourself? Reduce Pain Restore Health Maintain Health
Are you interested in Nutritional counseling? Yes No

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (For Minors): _____

Relationship to patient: _____ **Date:** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

CHIROPRACTIC CARE THAT STARTS WITH YOU

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X-Ray Consent

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

I understand that my doctor may need x-rays in order to help me and I give permission of all needed x-rays.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (For Minors): _____

Relationship to patient: _____ **Date:** _____

FEMALES ONLY

I understand that x-rays may be needed at some point and that by my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in anyway.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (For Minors): _____

Relationship to patient: _____ **Date:** _____

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Consent for Use and Disclosure of protected health information

With my consent, Zimmerman Family Chiropractic may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). With my consent, Zimmerman Family Chiropractic may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders and any call pertaining to my chiropractic care.

With my consent, Zimmerman Family Chiropractic may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Zimmerman Family Chiropractic for use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Zimmerman Family Chiropractic may decline to provide treatment to me.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (For Minors): _____

Relationship to patient: _____ **Date:** _____

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Terms of Care and Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards 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. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than correct your restricted brain to body communication. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of a health care provider who specializes in that particular area.

Regardless of what the disease is called, we do not 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 wisdom. Our only method is specific to make a correction to restore your brain to body communication.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care.

Prior to receiving chiropractic care in this Chiropractic office, a health history and chiropractic examination will be completed. These procedures are performed to assess your overall health and to see if you have restricted brain to body communication. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before care. In addition, they will help us determine if there is any reason to modify your care. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I hereby accept chiropractic care on this basis and consent to this care.

Patient's Signature: _____ **Date:** _____

Guardian's Signature (For Minors): _____

Relationship to patient: _____ **Date:** _____