Dr. Jerome J. Murphy, D.C.

Krohn Chiropractic Office, L.L.C.
607 Main St. Woburn, MA 01801
Phone: 781-933-7665 Fax: 781-933-9336
MurphyChiro.net

Please Print Clearly and Fill in Completely

Child (Age 5 to 17)

Print Name _____ Home Phone _____

Street Address _____ Cell Phone _____

City _____ State _____ Zip _____ Date of Birth _____

Mother's Name _____ (H) Phone _____ (W) Phone _____

Father's Name _____ (H) Phone _____ (W) Phone _____

Emergency Contact & Phone (different from parent): _____

Who may we thank for referring you to our office _____

Please Check: ❑Male ❑Female Handed: ❑Right ❑Left

Current Complaint:

Reason for seeking Chiropractic Care: _____Date of Onset _____

What makes your problem **better**? (Check all that apply):

❑Nothing ❑Lying down ❑Walking ❑Standing ❑Sitting ❑Movement/Exercise
❑Inactivity ❑Bending ❑Lifting ❑Pushing/Pulling ❑Other _____

What makes your problem **worse**? (Check all that apply):

❑Nothing ❑Lying down ❑Walking ❑Standing ❑Sitting ❑Movement/Exercise
❑Inactivity ❑Bending ❑Lifting ❑Pushing/Pulling ❑Other _____

How would you describe your pain? (Check all that apply):

❑Sharp/Stabbing ❑Achy ❑Dull ❑Shooting ❑Weakness ❑Throbbing/Gnawing
❑Numbness ❑Tingling ❑Burning ❑Constant ❑Comes & Goes

Current intensity of your pain (Circle one) No Pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

This complaint is: ❑Getting worse ❑Staying the same ❑Getting better

This complaint is at its worst: ❑In the morning ❑As the day goes on ❑In the evening ❑At night

This complaint interferes with (Check all that apply): ❑Sleep ❑Daily routine ❑Hobbies ❑Leisure

Have you seen any other doctor for this problem? ❑Yes ❑No Name: _____

Did any other doctor refer you here? ❑Yes ❑No Name: _____

Chiropractic History:

Have you ever been to a Chiropractor before? ❑Yes ❑No Dr _____

Date of last visit: _____ Reason for care: _____

Date of last x-rays: _____ How long were you under care: _____

Any other family members under chiropractic care? ❑Yes ❑No Dr. _____

Health History:

Name, Address & Phone # of PCP: _____

Describe any health problems & how long you have had them: _____

_____

List any current Medications: _____

Females Only: Are you or is it possible that you are currently pregnant? ❑Yes ❑No

Have you been vaccinated ❑Yes ❑No

Have you had any serious illnesses? ❑Yes ❑No

Have you had any surgery? ❑Yes ❑No

Have you had any major falls? ❑Yes ❑No

Have you had any car accidents? ❑Yes ❑No

Do/did you play sports? ❑Yes ❑No List: _____

Do you carry a book bag in school? ❑Yes ❑No Average Weight: _____ Both Shoulders ❑Yes ❑No

Rate the following (poor, good, excellent): Sleep _____ Diet _____ Exercise _____

Family History:

Please describe below any health concerns you may have about your:

Parents: _____

Siblings: _____

Consent to Treat a Minor:

I hereby authorize Krohn Chiropractic Office and those employed by the same to administer chiropractic care as deemed necessary to my child, _____.

Child's Name

Parent/Guardian Signature _____ Date _____

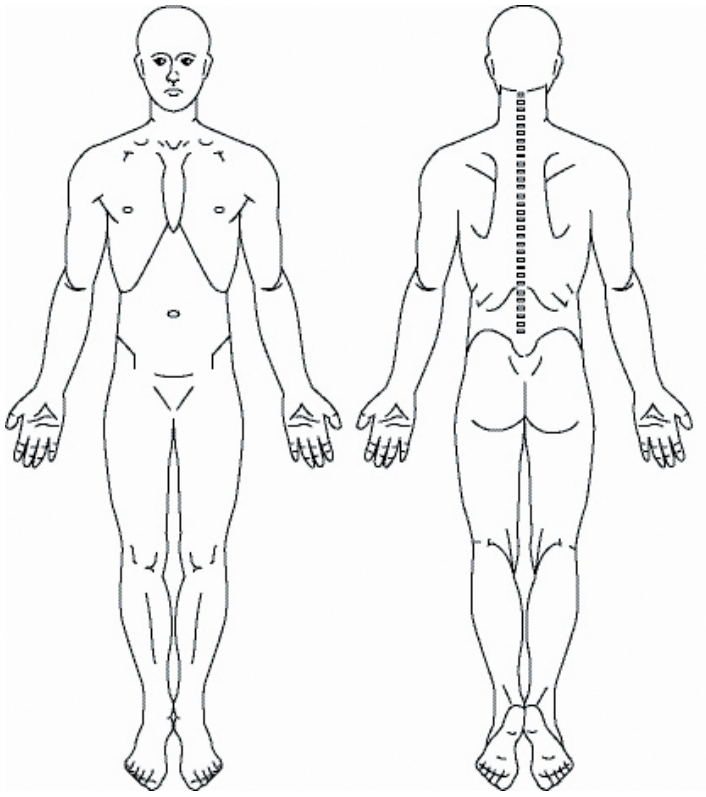
Please Check ✓ **any of the following conditions that you had or currently have:**

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Mark the area(s) on your body where you feel the described sensation(s). Mark areas of radiating pain and include all affected areas. Use the following symbol(s):

Aches ^^^^ Numbness **oooo** Pins/Needles ••••

Burning **xxxx** Stabbing / / / /



Please add any other health information you feel is important or we might need for your care:

_____

_____

_____

_____

_____

_____

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Consent to Chiropractic Examination

I here by authorize the performance upon myself of the following procedure: Examination and/or treatment

I realize that these procedures are to be performed by or under the direction of Chiropractic Physicians, employed at Krohn Chiropractic Office.

Physicians, Chiropractors, Osteopaths & Physiotherapists using manual manipulation are required to advise their patients that with neck problems there have been rare incidents of injury to the vertebral artery during the course of care. These have caused strokes or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 1 in 3-6 million adjustments. In addition, with neck or back problems there have been rare incidents of rib separation or fracture, bruising, swelling or aggravation of symptoms. APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOUR RISKS.

I hereby consent to the chiropractic care as indicated and explained to me. If during the course of care unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and care as may be indicated by sound and prudent chiropractic practice, which may require additional x-rays, chiropractic, orthopedic, neurological, and/or laboratory testing or consulting with another doctor.

No guarantee or warranty has been made to me regarding my results.

I have read and fully understand the above statements.

Guardian's Name: _____ Signature _____ Date _____

Witness : _____ Signature _____ Date _____

Consent to Initiate Care

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Health: A state of optimal, mental and social well-being, not merely the absence of infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of neural impulses, resulting in a lessening of the body's ability to express it's maximum 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 examination, we encounter non-chiropractic 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 the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate spinal subluxations through the method of specific adjustments.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis. I have read and fully understand the above statements.

Guardian's Name: _____ Signature _____ Date _____

Witness : _____ Signature _____ Date _____

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Privacy Policy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Krohn Chiropractic Office we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO or PPO or your employer, if they are or may be responsible for the payment of services provided to you.
Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your recent care or other health related information that may be of interest to you.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information with out your authorization in these following circumstances:

If we provide health care services to you in an emergency.
If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
If we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information an may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to review this information at an address other than your home or if you would like the information in a specific form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient files and the protected health information therein. We are also required to provide you with notice of our privacy practices with respect to your health information. We are further required by law to abide to the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible, following the changes. Any change in our privacy notice will apply for all your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our office manager.

If you would like further information about our privacy policies and practices please contact Dr. Jerome Murphy.

You have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue, and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 15, 2003. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Printed Name Signature Date

If you are a minor or if you are being represented by another party:

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient

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Office Policy

Appointment Policy

For your convenience, multiple appointments can be scheduled to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for each week, please note that it is the frequency that counts and not the days.

If you are unable to keep an appointment for any reason, we require that you reschedule as soon as possible. This office reserves the right to charge a $20 no show fee for missed appointments unless 24 hours notice has been given.

When entering the office on each visit please sign in at the front desk. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment.

Financial Policy

All services rendered in the office are the responsibility of the patient. If you have insurance, which includes chiropractic as a benefit, this office will extend the courtesy of processing insurance forms and mailing statements as necessary. If your policy has a visit limit or dollar amount cap, it is up to the patient to keep track of your insurance. This office is not responsible for keeping track of the limitations of our patient's policies. We do not guarantee that your insurance company will pay for the usual and customary fees of this office. Nor will we enter into dispute with your insurance company over reimbursement.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I understand that Krohn Chiropractic Office will prepare any necessary forms and reports to assist me in making collections from the insurance company. Any amount authorized to be paid to Krohn Chiropractic office will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALY RESPONSIBLE FOR PAYMENT. If I suspend or terminate my care any fees for services rendered will be immediately due and payable.

Patients are expected to make timely payments and to follow up with your insurance carriers as appropriate. Accounts are considered delinquent when they are 60 days old.

All payments are expected at the time of your visit and must be paid before you are treated. Under special circumstances payments may be postponed, but all balances must be paid in full by the end of each week. Patients may not exceed a $100 co-insurance balance.

If your deductible has not been met, you are expected to pay for services rendered until your deductible has been satisfied.

If your insurance policy changes or is canceled, this office must be notified as soon as possible.

If you do not have insurance that covers chiropractic care, we will be happy to arrange a Cash Plan for you.

If you discontinue care for any reason other that discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.

I certify that I have read and understand the above policies and agree to comply with said policies.

_____ _____

Signature Date