Bergkamp Chiropractic LLC Confidential Patient Forms

Name:_____Today's Date_____

Address:_____ City_____State_____ Zip_____

Cell:_____ Work_____ext_____ Home_____

Which contact phone number do you want messages left on? Cell Work Home

Email Address:_____

Last 4 of SSN#_____ Date of Birth_____ Age_____

Occupation_____ Employer_____

Marital Status: M S W D Spouse Name_____ DOB_____

Referred to our Office by_____ Internet Location

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

_____ PRIVATE SELF PAY (Cash, Check, or Major Credit Cards Accepted) I have no insurance, limited coverage, or a high deductible, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by KS state law, I am requesting a "Prompt Payment Discount" when I pay for my services on the same day that services are performed by enrolling in the ChiroHealthUSA program. Member enrollment fee is $49 for a year and covers all immediate family members on the same tax return. If I do not enroll in ChUSA, I will pay the regular fee for services provided today (see Good Faith Estimate posted).

_____ I would like this clinic to bill my insurance. Insurance only pays for care that helps you FUNCTION better; they DO NOT pay for maintenance care. I understand I am responsible for the costs of treatment should my insurance company deny coverage for all or part of the claim submitted on my behalf. I understand that I will be required to pay all copays or coinsurance percentages as stated in my insurance plan contract. I, the undersigned certify that I have insurance coverage and assign directly to Dr. Jill Bergkamp-Engle all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions and for card transactions.

All patients please note that you are ultimately responsible for timely payment in full at this office. Credit on accounts will remain in place until Dr Jill is notified of a credit refund request by you. In the event the total balance due is more than you are able to pay, please notify Dr Jill to make reasonable payment arrangements for you to continue care. The proposed care plan and alternative care options will be explained to you. I understand that results are not guaranteed. You are consenting to allow this office to begin care.

NOTICE OF PRIVACY PRACTICES for Bergkamp Chiropractic LLC is available at the front desk, in the reception area, and on our website at drjillchiro.com for viewing. I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices will be followed by this clinic to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained.

Patient or Legal Guardian Signature:_____

Please list the names and your relationship to whom you authorize this clinic to release info to:

Name_____Relationship_____

Name_____Relationship_____

Dr Jill Bergkamp-Engle DC ~ (316) 682-6161
11330 E Central Ave Ste 500 - Wichita KS 67206

Is chiropractic treatment safe?

Chiropractic is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of neuromusculoskeletal complaints. Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects and results are not guaranteed. The risks associated with chiropractic, however, are very small and may include: muscle spasms, lack of improvement, dizziness, nausea, fractures, dislocations, strains, sprains, disc conditions, or strokes. Many patients feel immediate relief following chiropractic treatment, but some may experience mild soreness or aching, just as they do after some forms of exercise. Current literature shows that minor discomfort or soreness following spinal manipulation typically fades within 24 hours.

Neck pain and some types of headaches are treated through precise cervical manipulation. Cervical manipulation, often called a neck adjustment, works to improve joint mobility in the neck, restoring range of motion and reducing muscle spasm, which helps relieve pressure and tension. Neck manipulation is a remarkably safe procedure. While some reports have associated upper high-velocity neck manipulation with a certain kind of stroke, or vertebral artery dissection, there is not yet a clear understanding of the connection. The occurrence appears to be very rare—1 in 5.85 million manipulations— based on the clinical reports and scientific studies to date. If you are visiting your doctor of chiropractic with upper-neck pain or headache, be very specific about your symptoms. This will help your doctor of chiropractic offer the safest and most effective treatment, even if it involves referral to another health care provider.

It is important for patients to understand the risks associated with some of the most common treatments for musculoskeletal pain -- prescription and over-the-counter nonsteroidal anti-inflammatory drugs (NSAIDS) -- as these treatments may carry risks significantly greater than those of chiropractic manipulation. According to a study from the American Journal of Gastroenterology, approximately one-third of all hospitalizations and deaths related to gastrointestinal bleeding can be attributed to the use of aspirin or NSAID painkillers like ibuprofen. Alternatives to the adjustment include: medicare care with medication, physical therapy, injections, surgery, self-administered care, massage, or acupuncture.

I understand that this visit will be used for evaluating pinched nerves of my spine. I have disclosed any and all important health related information for this visit. The following sensitive information will NOT be disclosed: abortion, genetic testing, maternity, sexually transmitted or other communicable diseases. My neurological and musculoskeletal systems are grossly intact therefore the standard of care procedures normally performed during an examination will be waived with my consent in order to get my structure functioning better by receiving a chiropractic adjustment.

It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based upon the facts then known, is in my best interests. The benefits and risks have been explained to you. You have been given the opportunity to ask questions. You are consenting to begin care to cover the course of treatment for your present condition and for any future conditions by signing below.

Patient/Legal Guardian Signature_____Date_____

Consent to Treat Minor Child Name(s):_____

CLINICIAN ONLY: Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was: Attested by:_____

- ❏ Of Legal Age
- ❏ Had Consent Given By A Guardian
- ❏ Assisted By A Translator/Interpreter
- ❏ Oriented x 3
- ❏ Unimpaired
- ❏ Fluent in English