TURACK CHIROPRACTIC
AND PERFORMANCE HEALTH

10850 PERRY HIGHWAY
WEXFORD, PA 15090
724.940.3499

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male - Female

INSURANCE INFORMATION

Who is responsible for this account?_____Relationship to Patient:_____

Insurance Company:_____ID#_____

Is patient covered by Additional Insurance? YES or NO

Subscriber's Name_____ Birthdate:_____

Relationship to Patient:_____

Insurance Company:_____ID#_____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly Dr. Daniel Turack all insurance benefits or the benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____Date:_____

Signature of Patient, Parent, Guardian

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen
☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List **ALL** **Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression
☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain
☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure
☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain
☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain
☐ Stroke/Heart Attack ☐ Other: _____

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List Type of **Medications** you are taking:

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

□ Other: _____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____

_____

Have you had any auto or other accidents? □ No □Yes Describe: _____

Date of last physical examination: _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Have you ever had chiropractic care? □No □yes

When? _____Why? _____

Where? _____

Were X-rays taken? ! No ! Yes

When was your last adjustment? _____

Informed Consent

Chiropractic, soft tissue techniques, and physiotherapy are very safe and effective forms of health care. It is in your best interest to be educated so that you can make an informed decision about your health. If at any time, throughout treatment, a question arises, please do not hesitate to ask the Doctor or staff. Patient education is our number one priority and we feel that an educated patient will receive greater benefit if they become involved in their own well-being.

Although it is uncommon, during any treatment there is an inherent risk of joint sprain, muscle strain, or bruising. Some patients may experience an increase in pain following the first few treatments due to muscle stretching and increased joint movement. These side effects may be temporary and the body may adapt to future treatments. All patients are thoroughly examined and will be verbally informed on the above such risks depending on what treatment is administered. I am also aware that I can discontinue my treatment at any time.

As part of your care, certain dietary supplements may be recommended to support your good health. This clinic is committed to recommending only well-documented, physician grade and science-based dietary

supplements. I understand that the recommendation of certain dietary supplements may be made to support the structure and function of my body and not to diagnose, prevent, treat or cure any disease. Many of our dietary supplements have not been evaluated by the Food and Drug Administration.

_____ _____

Patient Signature Date

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that you records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient **Date**

Signature