Patient Information

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Last Name _____ **First Name** _____ **Middle Initial** _____

Nickname you prefer to go by: _____ **Date of Birth** ___ _____ / _____ / _____

SS# _____

Gender: ☐ M ☐ F **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Home Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

Primary Number: ☐ Home ☐ Work ☐ Cell **Secondary Number:** ☐ Home ☐ Work ☐ Cell

Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone it is only as safe as you and your phone company's security.

Please check which source you would prefer for your reminders.

☐ **Text appointment reminders**

☐ **Emailed appointment reminders:**

Your Employer _____ **Occupation** _____

Emergency Contact _____ **Phone Number** _____ **Relation** _____

Whom may we thank for your referral? _____

CONDITION Workers Compensation Related? ☐ Yes ☐ No Auto Accident Related? ☐ Yes ☐ No

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.

The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fort Wayne Chiropractic I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request.

***Signature**_____ **Date**_____

My Privacy

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Fort Wayne Chiropractic to ensure the privacy of my personal health information.

***Signature**_____ **Date**_____

Acoustic Pressure Wave Therapy Informed Consent

Fort Wayne Chiropractic

Patient Name: _____

- What is APWT?
  - Acoustic Pressure Wave Therapy (APWT) is a series of high-energy focused shockwave percussions to the affected area which stimulates the body's natural healing process. This promotes the remodeling of dysfunctional collagenous tissues, such as tendinopathies, trigger points, muscle strains, etc. Shockwaves also break down scar tissue and/or calcification.
- What to expect?
  - Approximately 2,000 shocks are administered per treatment area. During APWT treatment, you may experience discomfort in the targeted area as the focused shockwave energy finds the damaged tissue to be repaired. The intensity of the treatment is specific to each patient's tolerance and will be adjusted as necessary. After an APWT treatment, you may experience temporary soreness or tenderness for a few hours and/or days as the shockwaves stimulate an inflammatory response. Patients on anticoagulants may experience more surface bruising on the treated area.
- Contraindications
  - Tumor diseases, carcinoma, cancer patients – no treatment on the specific area
  - Pregnancy – no treatment on specific area
  - Acute inflammations / pus focus in the target area
  - Pacemakers – treatments can only be performed from the waist down
- Consent to treat
  - Pain can increase temporarily. Bruising and/or swelling are also possible. We want you to be informed of all potential aspects of treatment. By signing below, you acknowledge that you understand and accept the risks, benefits, and cost of Acoustic Pressure Wave Therapy; and consent to have this therapy administered.

Patient Signature: _____ Date: _____

Acoustic Pressure Wave Therapy (APWT) Financial Policy

I understand that payment is due at the time of service. Each treatment is $60 and the treatment price is for one body area only, and any additional body areas that I would like APWT treatments to will be an additional cost. APWT is not billable to my insurance and must be paid out of pocket with cash, check, or credit card.

I understand that APWT appointment cancellations must be made 24 hours in advanced. A cancellation that is not made 24 hours in advance is considered a failed appointment. **I understand that 3 failed appointments during the calendar year will incur a $25 charge.**

Patient Signature: _____ Date: _____

Fort Wayne Chiropractic

Dr. Gregory J. Hough, D.C.

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name (print): _____ **Date Of Birth** _____

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Date of permission	**Name** of individual & **Relationship** with patient (parents for minors and spouses must be added if they are to have any access)	**Specify Information Allowed** (i.e. may call about appointment, may check balance, full access, etc.)
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____
		☐ Appointment information ☐ May check balances ☐ Full access ☐ Other _____

DR. HOUGH/STAFF HAS MY PERMISSION TO: (Please check all that apply)

☐Leave detailed message **at home** with my spouse

☐ Leave detailed message **at home** with**:** NAME: _____ Relationship:_____

☐Leave detailed message on my **cell phone** Cell phone number: _____

☐Leave detailed message on my **home answering machine** Home phone number: _____

☐Leave detailed message on my **voicemail at work** Work phone number: _____

In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to share the patient's date of birth with the staff.

_____ _____

Signature of patient or legal guardian Date