Patient Information

Fort Wayne Chiropractic

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

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

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/computer it is only as safe as you and your phone/email company's security.

Please check which source you would prefer for your reminders.

☐ **Text appointment reminders**

☐ **Email appointment reminders** **email address :** _____

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

Whom may we thank for your referral? _____

My Privacy

I acknowledge that a copy of the Notice of Privacy Practices is available for me to review 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 $70 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: _____

PERMISSION TO SHARE LIMITED HEALTH INFORMATION

Fort Wayne Chiropractic

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. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Name of individual (parents and spouses must be added if they are to have any access)	**Relationship with patient**	**Specify Information Allowed**
		☐ 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 _____

Fort Wayne Chiropractic has my permission to: **(Please check all that apply)**

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

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

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

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

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

_____ _____

*Signature of patient or legal guardian Date