Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
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nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

REGISTRATION FORM

Patient Information

Patient's Legal Name: _____ Date: _____

Preferred Name_____ Social Security #_____

Birth date: _____ Age: _____ Sex: M F

Marital Status: Married Sin Div Wid Sep Email Address: _____

Home Phone No:_____ Cell Phone No: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Employer Phone No: _____

Insurance Information

Insurance Company_____ Member ID#_____

How did you hear about our clinic?

CHECK ALL THAT APPLY _____Friend/Family _____Physician/Midwife _____Newspaper ____Radio

_____Event _____Internet/Google _____Phone Book _____Close to home/work ____Magazine

_____Other _____Malco Theatre _____Facebook _____Mail

Advertisement_____ Name of person who referred you: _____

Spouse Information

Spouse's Full Name: _____ Spouse's Birth date: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Work Phone: _____ Spouse's Cell Phone: _____

Do you have any children? Yes No If so, how many? _____

Emergency Contact Info

Name:_____ Relationship to Patient: _____ Phone No: _____

Please provide a copy of your driver's license and/or insurance card to the receptionist, for our records.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection and payment of medical bills from the insurance company. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately.

Patient Signature: _____ Date: _____

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Patient Case History

What is the current complaint? _____ How long has this been present? _____

Circle any other symptoms that may be present:

- Headaches
- Neck Pain
- Neck Stiffness
- Back Pain
- Back Stiffness
- Pins & Needles Arms
- Pins & Needles Legs
- Numbness in Arms
- Numbness in Legs
- Difficulty Standing
- Difficulty Sitting
- Difficulty Bending
- Difficulty Walking
- Difficulty Lifting
- Tension
- Irritability
- Anxiety
- Depression
- Insomnia
- Dizziness
- Nausea/Vomiting

Have you had similar symptoms before? Yes_____ No_____ How long ago? _____
Symptoms other than above _____
Have you seen another doctor for this condition? Yes_____ No_____ If yes, Dr. _____
Does the pain **radiate**? Y N Where: _____
Quality of Pain: Numb/Ache/Sharp/Dull/Stiff/Tight/Other: _____
Severity: 1 2 3 4 5 6 7 8 9 10 **Timing**: Constant/Intermittent/Daytime/Nighttime
Does anything make it better? _____
Does anything make it worse? _____
Have you been taking any medication for this condition? Yes____ No____ Medication Name: _____
List any surgeries you have had:_____
When was the surgery?_____
When did you last see a health care provider? _____
Are you allergic to any medication? Yes_____ No_____ What kind? _____
Are you currently taking medication? Yes_____ No_____ What kind? _____
Are you pregnant? Yes_____ No_____ How many weeks? _____

Do you have or have you ever had any of the following conditions:

- Allergies
- Anemia
- Arthritis
- Asthma
- Backaches
- Bowel/Bladder Dysfunction
- Cancer
- Cardiovascular Problems
- Concussions
- Convulsions
- Diabetes
- Digestive Disorders
- Ear/Nose/Throat
- Endocrine Dysfunction
- Epilepsy
- Hepatitis
- High Blood Pressure
- Multiple Sclerosis
- Neuritis
- Numbness
- Nervousness
- Sinus Trouble
- Respiratory

Relevant Family History_____

Is there anything else we need to know? _____
_____

Patient Signature: _____ Date: _____

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Informed Patient

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When VSCs are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT TO CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or learn from healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention to the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the Doctor **BEFORE** signing the Consent to Treat.

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Consent to Treat

The information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures and treatment as they deem necessary. I have read and understand the Informed Patient document. I also understand any nutritional counseling I may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Consent to Treat Minor

The information I have given this office pertaining to _____ is truthful and complete to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. I also understand any nutritional counseling my child/ward in my legal custody may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. I have read and understand the Informed Patient document. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Parent or Guardian Signature: _____ Date: _____

Relationship to Minor: _____

Doctor Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

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Patient Billing Acknowledgement Form Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

P R O V I D E R

Services to be provided:

- Supply _____
- DME: Posture Pump or TENS Unit_____
- Modalities/Procedures: Spinal Manipulation, Intersegmental Traction, Interferential, Manual Therapies, Therapeutic Exercises, Cold Laser, Ultrasound, Spinal Decompression, X-rays _____
- Other _____

Time frame from _____ through end of patient care.

Schedule/details: _applies to all visits_____

Provider Signature: _____

P A T I E N T

I _____, acknowledge that I have been told in advance by my

Patient Name – Printed or Typed

provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____

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Patient Billing Acknowledgement Form Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

P R O V I D E R

Services to be provided are listed below:

- Chiropractic Manipulative Therapy: 98940; 98942; 98941
- Modalities/Procedures: Intersegmental Traction, Interferential, Manual Therapies, Therapeutic Exercises, Cold Laser, Ultrasound, Spinal Decompression, X-rays
- Other: _____
- Time frame from _____ through end of patient care.
- Schedule/details: applies to all visits
- Provider Signature: _____

P A T I E N T

I _____, acknowledge that I have been told in advance by my
Patient Name – Printed or Typed provider
that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____