New Patient Information

The Burnley Clinic
Applied Kinesiology and Chiropractic

Name _____ E-mail Address _____

Home Phone_____ Mobile Phone _____

Address/City/State/Zip _____

Date of Birth _____Age _____ M ____ F_____Marital Status_____ # Children_____

Occupation _____ Referred By_____

Please check the appropriate space for any of the following symptoms that you have now or have had previously.
This is a confidential health questionnaire.

O = Occasional F = Frequent C = Constant

O	F	C	**General**
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headaches
☐	☐	☐	Insomnia
☐	☐	☐	Excess Weight Loss
☐	☐	☐	Excess Weight Gain
☐	☐	☐	Nervousness
☐	☐	☐	Depression
☐	☐	☐	Sweats
☐	☐	☐	Tremors

O	F	C	**Gastrointestinal**
☐	☐	☐	Belching or Gas
☐	☐	☐	Colitis
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Indigestion
☐	☐	☐	Distension
☐	☐	☐	Excess Hunger
☐	☐	☐	Gallbladder Problems
☐	☐	☐	Hemorrhoids
☐	☐	☐	Liver Problems
☐	☐	☐	Nausea
☐	☐	☐	Stomach Pain
☐	☐	☐	Poor Appetite
☐	☐	☐	Vomiting

O	F	C	**Cardiorespiratory**
☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	High Cholesterol
☐	☐	☐	Chest Pain
☐	☐	☐	Poor Circulation
☐	☐	☐	Rapid Pulse
☐	☐	☐	Slow Pulse
☐	☐	☐	Ankle Swelling
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Wheezing
☐	☐	☐	Spitting Up Blood
☐	☐	☐	Spitting Up Phlegm

			Muscle and Joint
☐	☐	☐	Arthritis
☐	☐	☐	Food Trouble
☐	☐	☐	Hernia
☐	☐	☐	Low Back Pain
☐	☐	☐	Neck Pain
☐	☐	☐	Poor Posture
☐	☐	☐	Sciatica
			Pain/Numbness In:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Wrist/Hand
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet

			EENT
☐	☐	☐	Asthma
☐	☐	☐	Colds/Flu
☐	☐	☐	Crossed Eyes
☐	☐	☐	Dental Decay
☐	☐	☐	Ear Problems
☐	☐	☐	Enlarged Glands
☐	☐	☐	Eye Pain
☐	☐	☐	Near-sightedness
☐	☐	☐	Far-sightedness
☐	☐	☐	Gum Problems
☐	☐	☐	Hay Fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal Obstruction
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus Problems
☐	☐	☐	Sore Throat

			Skin
☐	☐	☐	Boils
☐	☐	☐	Bruise Easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or Rash
☐	☐	☐	Itching
☐	☐	☐	Varicose Veins
			Genitourinary
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Frequent Urination
☐	☐	☐	Painful Urination
☐	☐	☐	Pus in Urine
☐	☐	☐	Kidney Stones
☐	☐	☐	Prostate Problems

For women only:

Date of last period (day 1): _____

Birth Control: _____

☐	☐	☐	Menstrual Problems
☐	☐	☐	Hot Flashes
☐	☐	☐	Irregular Cycle
☐	☐	☐	Menopausal Symptoms

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Is this problem getting worse? _____ Constant? _____ Worse in morning? _____ Evening? _____

Is this interfering with work? _____ Sleep? _____ Exercise? _____ Other? _____

What do you believe is wrong with you? _____

List other problems you have now _____

_____

List past operations and dates _____

_____

Have you ever been hospitalized other than for surgery? _____

What is your stress level? _____

Have you ever had any mental or emotional disorder? _____

Have you had any other injury in the past two years? _____

Are you taking medication? _____ Describe _____

Are you taking nutritional supplements? _____ Describe _____

_____

Are you allergic to any foods, drugs, etc.? _____

Do you frequently skip meals? ..... Yes _____ No _____

Do you have to watch what you eat to avoid gaining weight? ..... Yes _____ No _____

Do you have to watch what you eat to avoid losing weight? ..... Yes _____ No _____

What foods do you especially like? _____

_____

_____

What foods do you dislike? _____

_____

_____

Do you feel that your diet is excessive in some respect? ..... Yes _____ No _____

If yes, describe. _____

_____

_____

Do you feel your diet is deficient in some respect? ..... Yes _____ No _____

If yes, describe. _____

_____

_____

Do you have any dental problems? _____ Dr.: _____

Do you wear arch supports? _____ Heel lifts? _____ Special shoes? _____ What is your shoe size? _____

Date of your last physical exam? _____ Dr.: _____

Habits (describe with amounts):

Alcohol _____ Coffee _____

Cigarettes _____ Drugs not listed above _____

Describe your present exercise habits (or attach additional page): _____

_____

Please list the main health problems in your family:

Name: Relation: Problem:

_____

_____

_____

In case of emergency, please list the name and number of a friend or relative NOT living with you:

_____

Signature: _____ **Date:** _____

Symptom Survey

Patient Name _____ Date _____

Please list below the five main complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all prior and/or current injuries.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Financial Policy

The Burnley Clinic is committed to the success of your chiropractic treatment and better health. Your clear understanding of our financial policy is important to our professional relationship. Payment is due when the service is rendered. Our office accepts Visa, MasterCard, and Discover as well as cash payment and current personal checks.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information concerning any of these policies, we would be happy to help you.

Do you accept insurance?

The Burnley Clinic accepts most major insurance plans; however, we are only In Network with BlueCross Blue Shield. Others will be considered Out of Network. If you have a BlueCross BlueShield HMO plan, you will need to get a referral from your Primary Care Physician prior to your new patient visit at our clinic.

For automobile accidents, we accept Personal Injury Protection (PIP) insurance plans.

Unfortunately, we are not a participating provider with Medicare or Medicaid.

Is chiropractic care covered by most insurance companies?

Most insurance companies do cover chiropractic care; however, each plan and company has different coverage. Our office is happy to verify your benefits. You are also welcome to contact your insurance company to better understand your benefits. We request at least 24 hours in order to verify benefits prior to your visit. Verification of benefits is NOT a guarantee of payment.

What is my financial responsibility?

If you have…	***You are responsible for…***	***Our staff will…***
PPO/HMO that we are contracted with	If services you receive are covered by this plan, your applicable copays, deductibles, and coinsurance are requested at the time of visit. If the services you receive are not covered by the plan, payment in full is required at the time of the office visit.	File all necessary insurance claims.
PPO/HMO that we are not contracted with	Payment in full for all services not covered by out-of-network providers must be paid at the time of your office visit.	File all necessary insurance claims.
No insurance (or you prefer not to use your insurance plan)	Payment in full is required at the time of your visit.	Provide you with a receipt.
Personal Injury Protection	Services are usually covered if patient has Personal Injury Protection (PIP) or MedPay Insurance. If the accident is disclosed, health insurance may cover the claim as well. We do not accept assignment on third-party liability or attorney's letter of protection.	File all necessary insurance claims.

To summarize, your financial responsibility is:

- Denied and non-covered services;
- Services deemed not medically necessary by your insurance company;
- Co-payments, deductibles, and coinsurance; and
- Non-insurance and/or out-of-network benefits.

What if my child needs to see the doctor?

A parent or legal guardian must accompany patients who are minors on all of the minor patient's visits. This accompanying adult is responsible for payment of the account.

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What if I need to cancel my appointment?

We understand that things come up and emergencies happen. However, there may be others with health care needs who are seeking treatment, but are unable to come in when our schedule is full. Therefore, we require a 24-hour notice for cancelled appointments. Charges may be incurred if appointments are cancelled with less than a 24-hour notice.

What if my check is returned for any reason?

Returned checks will incur a $30.00 service charge in addition to any other bank fees accrued by this office in the collection of funds. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge and fees.

I have read, understand, and agree to the above Financial Policy. I understand that all charges not covered by my insurance company, as well as applicable co-payments, deductibles, and coinsurance, are my responsibility.

I authorize The Burnley Clinic to release pertinent patient information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to The Burnley Clinic.

Patient Signature:

_____ Date: _____

Signature of Patient's Representative (if minor or physically incapacitated):

_____ Date: _____

Relationship to Patient:

_____

The Burnley Clinic
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Informed Consent

To the patient: Chiropractic doctors, medical doctors, osteopaths, and physical therapists that perform adjustment/manipulation are required by law to obtain your informed consent before starting treatment. Please read this entire document prior to signing it. It is important that you understand the information contained in this document. You are encouraged to ask questions if there is anything that is unclear and discuss any concerns with Dr. Burnley before you sign.

The nature of the chiropractic adjustment. The primary treatments Dr. Burnley uses as a Doctor of Chiropractic are spinal and extremity manipulative therapies, also known as chiropractic adjustments. Dr. Burnley may use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment. As a part of your analysis, examination, and treatment, below is a list of procedures Dr. Burnley may use to treat you. *Please initial each procedure below that you consent to.*

_____ chiropractic adjustments	_____ orthopedic testing	_____ cold laser therapy
_____ range of motion testing	_____ postural analysis	_____ neurological therapy
_____ muscle testing	_____ basic neurological testing	_____ vital signs
_____ palpation	_____ physical therapy techniques	_____ emergency medical services

Treatment results. There are many beneficial effects associated with these treatment procedures, including decreased pain, improved mobility and function, and reduced muscle spasm. By removing interferences identified during examination, such as misaligned bones, tight connective tissue, nutritional deficiencies, poor dietary habits, and imbalanced meridians, the human body is positioned to heal naturally. However, chiropractic treatment is not an exact science, and the outcome of these procedures is not guaranteed.

The material risk inherent in chiropractic adjustment. Although chiropractic adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, as with any healthcare procedure, there are certain complications that may arise during treatment. These complications include, but are not limited to, fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains, and separations. Some types of manipulations of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications, including stroke. This very rare event occurs during manipulation with the head in a rotated and extended position – a method of adjusting not used in this clinic. Some patients will feel stiffness and soreness following the first few days of treatment. Dr. Burnley will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to his attention, it is your responsibility to inform him.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone that Dr. Burnley checks for during the taking of your history and during examination, and in some cases, X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include:

Medications: Medication can be used to reduce pain or inflammation. Long-term use or overuse is always a cause of concern. Drugs may mask pathology and produce inadequate or short-term relief. The potential risks of these medications include undesirable side effects, such as irritation to stomach, liver, and kidneys, and physical or psychological dependence. Some medications may involve serious risks.

Rest: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness.

Surgery: Surgery may be necessary for joint stability and serious disk rupture. Surgical risks may include unsuccessful outcome, complications, adverse reaction to anesthesia, as well as an extended recovery period in a significant number of cases.

Non-treatment: The potential risks of refusing or neglecting care may include increase in pain, scar and/or adhesion formation, restricted mobility, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

If you choose to use one of the above noted "other treatment" options, you should be aware of the risks and benefits of such options and discuss these with your primary care physician.

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DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustment and related treatments. I understand the information above and have had my questions answered to my satisfaction by Dr. Burnley. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment on me or the person named below for which I am legally responsible. I understand results are not guaranteed. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I further understand that it is my responsibility to inform this office of any changes in my medical status.

Date

Date

Patient Name (print)

Doctor Signature

Patient Signature

Signature of Parent or Guardian
if patient is a minor or physically incapacitated

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Electronic Communications Consent

Electronic communications offer an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over in-person or telephone communications. Below are our rules for contacting our clinic or Dr. Burnley using e-mail:

- E-mail is never appropriate for urgent care or emergencies! Please call our office or go to the nearest urgent care or emergency room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. However, for those questions or inquiries that require more time to discuss, please call our office.
- E-mails should not be used to communicate sensitive personal or medical information.
- E-mail is not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- Finally, either one of us can revoke permission to use e-mail electronic communications at any time, which will impact future and not past communications.

E-mail Communications Consent

I have read the above information and understand the limitations of security on information transmitted electronically.
(*Please initial consent option below*.)

_____ **Yes**, I have read this document and consent to e-mail communication with my doctor/staff electronically.

_____ **No**, I do not consent to e-mail communication and do not want to communicate with my doctor/staff electronically.

Appointment Reminders Consent

The Burnley Clinic offers appointment reminders via e-mail and/or text message. We do not offer appointment reminders via telephone.
(*Please initial consent option below*.)

Email Reminders:

_____ **Yes**, I authorize The Burnley Clinic to send appointment reminders electronically via e-mail to the e-mail address provided below. I understand that my contact information will not be sold to third parties.

_____ **No**, I do not authorize The Burnley Clinic to send appointment reminders electronically via e-mail.

Text Reminders:

_____ **Yes**, I authorize The Burnley Clinic to send appointment reminders electronically via text message to my mobile phone. I understand this service is offered free of charge, however standard text message rates from my mobile carrier may apply. Please activate text message reminders for the following patient and mobile phone listed below. I understand that my contact information will not be sold to third parties.

_____ **No**, I do not authorize The Burnley Clinic to send appointment reminders via text message.

Please complete all information below:

E-mail Address _____

Mobile Number _____

Patient Name (Print) _____

Name of Patient Representative (Print)
if patient is a minor or physically incapacitated
_____

Signature of Patient _____

Signature of Patient Representative _____

Date _____

Relationship to Patient _____

The Burnley Clinic
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HIPAA Acknowledgement

Use and Disclosure of Your Protected Health Information

Your Protected Health Information ("PHI") will only be used by The Burnley Clinic, LLC or disclosed to others outside of our office that are involved in your care for the purposes of treatment, obtaining payment, and/or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices ("Notice") for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. A copy of the Notice is available on our website at www.theburnleyclinic.com, or you may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

I understand the situations in which this practice may need to utilize or disclose my PHI. I understand that I agreed to the use and disclosure of my PHI when I initially sought treatment at this office on my first visit, whenever that may have occurred. I understand my rights with regard to my PHI. I also understand that this office will properly maintain my PHI and will use all due means to protect my privacy as outlined in the Notice.

Name of Patient (Print)

Signature of Patient

Date

Others we may release your PHI to (e.g., family members, relatives, or close friend):

Name of Patient Representative (Print)
if patient is a minor or physically incapacitated

Signature of Patient Representative

Relationship to Patient

Date