Eastern Chiropractic Centre
Dr. Todd Salow
112 E. Washington St
Washington, IA 52353
(319) 653-6000
Fax (319) 653-6115

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ Suffix _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Email _____

Date of Birth [/ /] Gender: ❑ Male ❑ Female ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Emergency Contact (Name and Number) _____

Employment Status: ❑ Employed ❑ Retired ❑ Student

Place of Employment _____

Privacy Statement (HIPAA)

I consent to the release of my personal health information by Eastern Iowa Chiropractic Centre for use in treatment, payment, or health care operations. I have been given the opportunity to review the privacy notice describing the policy and procedures of Eastern Iowa Chiropractic Centre regarding the release of my personal health information. I understand that this consent shall remain in force and effect unless it is revoked in writing.

_____ _____

Signature Date

EASTERN IOWA CHIROPRACTIC CENTRE

DR. TODD SALOW

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ Last Name:_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred Language: _____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____

OFFICE USE ONLY

HEIGHT:_____ WEIGHT:_____ BLOOD PRESSURE:_____ PULSE: _____

EASTERN IOWA
CHIROPRACTIC
CENTRE

DR. TODD L. SALOW

Informed Consent to Chiropractic Adjustment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and /or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I've had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. These complications are rare. I may feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the doctor's attention, it is my responsibility to inform him.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

Patient Name: _____

Pt/Guardian Signature:_____

Date:_____

Witness: _____

Eastern Iowa Chiropractic Center Dr. Todd Salow

112 E. Washington

Washington, IA 52353

Assignment and Release

Eastern Iowa Chiropractic Centre is authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred. I assign directly to Eastern Iowa Chiropractic Centre all medical benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree that this authorization and release is irrevocable and ongoing until all monies owed are paid in full and will be in continual effect until revoked by both parties.

_____ _____

Signature Date

Office Policy

We believe that a clear understand of our office policies will allow us to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH.

Appointments

When entering our office you must "sign in". We attempt to honor all appointments at the scheduled time. IF you are late, you may have to wait for the next available appointment. If you are unable to keep an appointment, please call immediately to reschedule your visit. It is to your benefit to make up a missed appointment within 7 days of any cancellation. Regardless of how many appointments you have in a week, please note that it is the frequency of the visits that counts, not the days.

Financial

All payments are expected at the time services are rendered. Balances will not exceed $170.00 at any one time. Balances over 30 days will be subject to 1.5% charge. Returned checks will be subject to a $20 insufficient funds fee. You are ultimately responsible for all charges.

_____ _____

Signature Date