New Patient Application

Welcome to MacFarland Chiropractic! Please thoroughly complete all information and questions.

Name:_____ Today's Date:_____

Address:_____

City/State/Zip:_____

Email:_____ Birthdate:_____/_____/_____

Phone: Home:_____ Cell:_____ Work:_____

Who may we thank for referring you?_____

Your Prior Doctor of Chiropractic and Location:_____

Your Employer:_____ Occupation:_____

Status: S/M/D/W Spouses Name:_____

Children's Names and Ages:_____

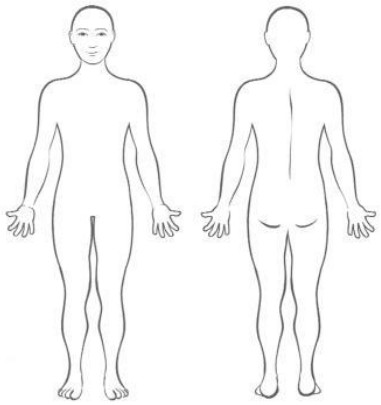
Favorite Hobbies and Interests:_____

Health Reasons for Consulting our Office?

1._____ 2._____

3._____ 4._____

Please indicate the areas of discomfort below:



Have you had similar problems before? Yes____ No____

How long? Please Explain:

_____

_____

Father/Mother/Sister/Brother with the same problem?

_____

Is this the result of an auto or work injury? Y or N If so, When?_____

Other doctors who have treated this problem?_____

_____

Previous Surgeries:_____

_____

Current Medications:_____

_____

Females: Is there any chance you may be pregnant? Y or N

What have you heard about Chiropractic Care?_____

Do you know what a subluxation is? If yes please describe:_____

_____

Do you currently perform daily spinal exercises? If so, which ones?_____

_____

Have you ever been diagnosed with cancer? If so, which type? _____

_____

In order for us to better understand your current level of health, please check any of the following body signals that you have or have experienced:
____Dizzy or Fainting ____Headache ____Postural Imbalance ____Arthritis ____Asthma
____Ear Infection ____Intestinal Problems ____Sinus Problems ____High Blood Pressure
____PMS ____Frequent Colds ____Bladder Problems ____Menopausal Symptoms

To help us better explain your chiropractic condition and how we may be able to help you, please check the best answer:

"I remember important things in my life by":

____What I see ____What I hear ____What I feel

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement.
Patient or Guardian Signature:_____

Patient Financial Responsibility

Patient Name/Guarantor:_____
DOB_____

MacFarland Chiropractic appreciates the confidence you have shown in choosing us to provide for your health care needs. As a courtesy, we will verify your insurance coverage and bill your insurance carrier on our behalf. If the insurance carrier does not make full payment for any reason, you are ultimately responsible for your bill.

You are responsible for payment of any deductible or co-payment/co-insurance as determined by your contract with your insurance carrier. We expect co-pays to be paid at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurance carrier. If you insurance carrier denies any part of your insurance claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to MacFarland Chiropractic, LLC, for providing services to me or the patient named above. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurance to pay any benefits to MacFarland Chiropractic, LLC, the full or entire amount of the bill incurred by myself or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature:_____
Date:_____

MacFarland Chiropractic
13 Red Roof Lane, Suite 2
Salem, NH 03079
(603) 818 6771

Privacy Policy:

In order to provide you with care in our facility, you have provided personal information about yourself, some of which may be nonpublic in nature. We have a high regard for the privacy of our patients and want you to know how we handle your personal information. The following contains a description of the types of information we collect about you, and how the information is used and protected. This privacy statement describes our privacy practices for both our current and/or former patients.

Types and Sources of Information We Collect About You:

We collect information about you, including nonpublic personal information, from the following sources:

- Information we receive from you on your case history form, as well as other forms related to your patient files.
- Information about your transactions with us, which may include your payments and payment history.
- Information we receive from your current and former physicians.
- Information we receive in reference to your current medical insurance policies.

Our Use of the Information That We Collect About You:
We use the information we collect about you, including the nonpublic, personal information, only for the purposes of evaluating, effecting and administering, enforcing, and servicing your care with our facility. We do not disclose any non-public personal information about your to any non-affiliated third parties, except as provided by law. We do not forward or otherwise share your information with anyone without prior written consent from you, the patient.

Protection of Your Information:
We restrict access to the nonpublic information about you to only necessary employees, unless requested from the patients themselves. Our facility has adopted an information security program that includes administrative, technical, and physical safeguards to protect the security and integrity of your nonpublic information.

Signature: _____
Date: _____

Informed Consent

While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care so you can be fully informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, physical exams, exercise instruction, physical therapeutics, etc. When your chiropractor is not available, another Doctor of Chiropractic may treat you.

Specific risk possibilities associated with chiropractic care:

Soreness: Chiropractic adjustments and physical therapeutic procedures are sometimes accompanied by post treatment soreness. This is a normal and accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience any soreness during or after treatment.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate an existing disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize such risks.

Physical Therapeutic Burns: Heat generated by physical therapeutics may cause minor burns to the skin. These are rare and should be reported to your Doctor of Chiropractic or staff member as soon as possible.

Stroke: Stroke is the most serious, potential complication of chiropractic treatment. In rare instances, a neck adjustment or manipulation can cause stroke, and could cause temporary or permanent brain injury. On extremely rare occasions, death may occur due to stroke. The most recent studies estimate that the incidence of this type of stroke is 1-2 incidents in every 1 million cervical adjustments. This level of risk is substantially lower than the risk of serious complications from using non-steroidal anti-inflammatory drugs.

Other Problems: There are rarely other types of side effects associated with chiropractic care. Any unusual responses should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care. Therefore, as with any health care, we cannot guarantee or promise you a cure for any symptom, condition, or disease as a result of treatment in this office. We attempt to provide you with the best care that we can. If the results are not acceptable, then we will refer you to another health care provider who we feel would best help your situation.

If you have any questions concerning your treatment, please ask your Doctor of Chiropractic. When you have full understanding, and consent to have care provided, please print your name and sign and date below,

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment and adjunctive procedures administered by Dr. Craig E. MacFarland.

_____ _____

Patient Name Printed Dr. Craig E. MacFarland

_____ _____

Patient Name Signed Date: