Welcome to Restored Health Chiropractic Center!

Thank you for choosing our office for your health and chiropractic needs! We are delighted to have you as part of our practice and are committed to providing you with the best chiropractic experience.

Our office is exclusively in-network with Blue Cross Blue Shield (BCBS). If you have BCBS for insurance, please bring a form of picture ID and your insurance card to your initial appointment.

If you are not insured by BCBS, our cash rates are as follows:
New Patient Exam, including initial adjustment: $150
Follow-Up Adjustments: $75
We also offer a couple of different options for adjustment packages for our out-of-pocket patients. HSA and FSA funds can be used to purchase these packages.

Additionally, RHCC has a team of incredible licensed massage therapists who specialize in medical massage. As a new patient to our office, we are pleased to offer $15 off your first massage with us.

Please fill out the enclosed paperwork and bring it with you to your appointment. If you are unable to print the paperwork and fill it out ahead of time, no problem! Please arrive 20 minutes early so that you can complete it prior to your scheduled appointment time.

We do require a $100 fully refundable deposit when scheduling a new patient exam appointment. We make specific preparations for your first visit with us and are committed to being thoroughly prepared for your appointment. We understand that situations arise where you may be unable to keep your reserved appointment time. If you are unable to make your scheduled appointment, we ask that you please give us a 24 business hour notice so that we can use the time reserved for your new patient exam to help other patients. Failure to provide appropriate notice may result in your deposit being forfeited.

If you have any questions, please feel free to call our office directly at 616.458.2348, text us at 616.383.2826, or email us at Info@RestoredHealthChiro.com

OUR PRACTICE ETIQUETTE

Welcome! We are so honored that you have chosen Restored Health Chiropractic Center for your health and wellness needs. For the best possible experience, please review our guidelines and tips.

- If you are feeling unwell or have any symptoms such as coughing, sneezing, fever, chills, etc., please notify the office and we will request that you reschedule once you are feeling better.
- Please allow ample time if you need to reschedule your appointments. We require at least a 24 business hour notice to avoid a late cancel/no-show fee of $45 per missed appointment. You may email or call to cancel or reschedule.
- Please silence cell phones upon arrival. We are committed to providing the best care to each and every patient and having both the doctor and patient 100% present makes this much more attainable
- Fragrances can be distracting and, at times, overpowering for our team members and patients. Please refrain from wearing any fragrances when possible, or keep to a minimum.
- We optimize booking for our massage sessions and allocate approximately 2-3 minutes for disrobing and changing into your clothing after your session has been completed. Please be mindful of this after your massage.
- If you are satisfied with your massage therapy experience and would like to leave a gratuity for your massage therapist, there are 3 ways to do so if you desire: Cash, Credit Card (3% processing fee incurred), and Venmo. Typical industry standard gratuity is 15-20% of the face value of your service rendered. Gratuity is never expected, but always appreciated.
- Later appointment times are the most coveted. If you have a day, time, and/or doctor, and therapist preferences, it is advisable that you pre-book in advance to best accommodate your needs.
- Curious about other offerings that our office provides? Ask us about…
    - Hot Stones and/or Myofascial Cupping: massage add-ons
    - Hair/Saliva Testing, Functional Medicine
    - Whole Food Supplements and Clinical Nutrition
    - Pillowise Custom Fitted Pillows
    - Saatva Mattress
    - Craniosacral Therapy
    - Medical Acupuncture
- We offer a referral program that rewards you with a $10 in-office credit for each friend or family you refer to our office!

TREATMENT CONSENT FORM

Patient Name: ______________________________________Date:____________

TREATMENT CONSENT
I have had the following consents and authorizations explained to me. My signature indicates my approval while I am receiving services at Restored Health Chiropractic Center (RHCC) to include all care for my condition.
Please read and initial:

______ I consent to all treatment, diagnostic tests, and therapeutic procedures and care by RHCC. I am aware that the practice of chiropractic, and massage therapy is not an exact science. I acknowledge that no guarantees have been made to me as to the results of the recommended treatments.

______ I understand that, as with any health procedure, certain complications may arise during a chiropractic adjustment or massage. These complications include, but are not limited to fractures, dislocations, muscle strain, costovertebral strains, and separations.

______ I understand that the Doctor/Massage Therapist is not able to anticipate all risks and complications that could arise as a result of the recommended treatment. Based upon the facts known at the time, the recommended treatment(s) are in my best interest.

______ I understand that RHCC is not responsible for the loss of clothing, money, valuables, glasses or any other of my personal items and I understand that I should make arrangements to safeguard items during my appointment times.

Patient Signature: ____Date: _____________

Guardian's Signature: _______________________________________Date: _____________

FINANCIAL AGREEMENT, RECORDS AUTHORIZATION, AND INSURANCE ASSIGNMENT OF BENEFITS

We are happy to submit adjustment claims to your insurance carrier as a courtesy to you. We participate exclusively with Blue Cross Blue Shield. We will perform a benefits check for you, but you are ultimately responsible for knowing the coverage and limitations of your insurance policy. Your insurance company makes the final determination of eligibility and benefits payable at the time your claim is processed.

The estimated patient portion of treatment will be due in full at the time of service. Keep in mind that the estimated patient portion is just an ESTIMATE. Your actual patient portion may be more or less depending on your coverage when the claim is processed. YOU ARE RESPONSIBLE FOR THE AMOUNT NOT COVERED BY INSURANCE.

Please read and initial:

______ I agree to pay RHCC for all services and supplies, according to its regular rates and charges, at the time these services and supplies are rendered. If this account is delinquent, I agree to pay all expenses including, but not limited to, court costs and actual attorney fees incurred by RHCC in collecting this account. I also agree to assign to RHCC any right or cause of action that I may have against any third person to collect and recover for the expense of this account.

______ I further authorize RHCC to release any billing information for payment of account by any insurance company or employer. I authorize any insurance companies to pay directly to RHCC liability and/or medical insurance proceeds for all services and supplies rendered by RHCC for treatment. I understand that I am financially responsible to RHCC for all services and supplies not covered by the liability and/or medical coverage insurance.

______I understand that RHCC is exclusively in-network with **Blue Cross Blue Shield** and services I receive will be billed directly to BCBS through RHCC. I understand that if I do not have Blue Cross Blue Shield, I am required to pay out of pocket for services rendered.

______I understand that it is my responsibility to notify RHCC of any changes in my insurance plan(s) and that denial due to lack of coverage in the event of any insurance change is my financial responsibility.

______I understand that RHCC contracts with me, as the patient, and not with my insurance company and that I am responsible for understanding my insurance benefits.

_____If my benefits are exhausted, or I fail to notify RHCC that I am receiving chiropractic services at another facility, I accept responsibility for any unpaid balances.

______ If my benefits are exhausted, or I fail to notify RHCC that I am receiving chiropractic services at another facility, I accept responsibility for any unpaid balances.

METHODS OF PAYMENT

Payment is due at the time of service. We accept the following payment types:
-Cash
-Check
-Visa, Mastercard, Discover, and American Express
- HSA/FSA

MEDICAL RECORDS AUTHORIZATION AND DISCLOSURE

I authorize RHCC to release the minimum necessary information contained in my patient record (including photographs, videotapes, audio recordings or other digital images) to other healthcare providers for continuing care needs or to my insurance company or employer for payment of my account.

I understand that as part of my treatment, Restored Health Chiropractic Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as 1) a basis for planning my care and treatment, 2) a means of communicating among the health professionals involved in my care, and 3) a means by which a third-party payer can verify that services billed were provided.

NOTICE OF PRIVACY PRACTICE

I understand and have been provided (or can be provided at my request), a Notice of Privacy Practices. I understand that this notice outlines how RHCC may share my health information for treatment, payment, and healthcare operations.

CONSENT TO CONTACT

I have provided RHCC with residential/cellular phone numbers and/or emails. I consent and agree to permit Restored Health Chiropractic Center, its agents, or contractors, including the collection agency to contact me at the telephone numbers provided. I may opt out of receiving this information at any time by notifying RHCC to remove me from the contact list.

PATIENT REPRESENTATIVE

I authorize Restored Health Chiropractic Center staff permission to verbally share my medical information on voicemail or in person with the following person(s):

Name	Relationship	Phone Number

OFFICE POLICIES

LATE ARRIVAL

If you arrive later than your appointment time, it may be necessary to reschedule the appointment or you may be asked to wait longer than usual. Our team will do our best to complete all services, but if time constraints exist, some services may need to be rescheduled for a later date. This ensures that we meet our patient's expectations and remain on schedule.

CANCELLATION AND NO-SHOW

As a courtesy to our patients, we send text/email appointment reminders the day before their scheduled appointment. The text/email reminders are not guaranteed, and the fee is not waived if an appointment reminder does not get sent.

______ I understand that if I am unable to keep my scheduled appointment it is my responsibility to give RHCC at least a 24 business hour notice if I need to cancel or reschedule my appointment. **I understand that if I fail to give advance notice, I will be charged $45 per missed appointment.**

Patient Signature: ____Date: _____________

Guardian's Signature: ____Date: _____________

NEW PATIENT FORMS

DEMOGRAPHICS

Name: ________________________________DOB: _______________________________
Cell Number: ___________________________ Other Phone Number:_____________________
Email: ______________________ SSN:______________________
Billing Address: ____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other
Children: ☐ Yes ☐ No If yes, how many:______

In case of emergency, contact: ____________________ Relationship: _______________
Phone:_______________________

EMPLOYMENT

☐ Full-time/Place of Employment:_______________________
☐ Part-time/Place of Employment: ______________________
☐ Self-employed/Place of Employment:__________________
☐ Unemployed
☐ Retired/Date of Retirement: __________________________
☐ Student/School Name:______________________________

INSURANCE

Do you have Blue Cross Blue Shield for health insurance? (If “no”, your care will be an out-of-pocket expense.) ☐ Yes ☐ No
Who is the subscriber of your insurance? (If you are the policyholder, write ‘self’)
Name: __________________________ DOB:________________
Gender: ☐ Male ☐ Female
Relationship to Patient:___________________

Is your appointment related to an auto accident? ☐Yes ☐No
Name of Insurance Company:________________________ Claim Number:________________
Adjustor Name:__________________________ Adjustor Phone Number:__________________
Date of Accident:______________

HOW DID YOU HEAR ABOUT US?

☐ Social Media ☐ BCBS Website ☐ Google/Yelp
☐Friend/Family
☐ Other ☐ Current RHCC Patient ☐ Physician/Referral

If you were referred by someone, please let us know their name. We love rewarding current patients who send their friends/family our way!
Referring Patient: ____
Referring Physician: ____

Have you received chiropractic care before? ☐ Yes ☐ No

MEDICAL HISTORY
Please indicate whether you have experienced any of the following:

☐Alcoholism
☐Allergies
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Bleeding Disorder
☐Bronchitis
☐Cancer
☐Clotting Disorder
☐ Depression
☐ Diabetes
☐ Digestion Problems
☐ Epilepsy
☐ Headaches
☐ Herniated Disc
☐ Migraines
☐ MS
☐ Nose Bleeds
☐ Osteoporosis
☐ Pacemaker
☐ Pinched Nerve
☐ Stroke
☐ Thyroid Condition
☐ Ulcers
☐ Pinched Nerve
☐Other:__________

Please list any medications/supplements you are currently taking:________________________
____
____

Please list any surgeries or recent hospitalizations:_____________________________________
____
____

PHYSICAL & TRAUMA INFORMATION
Work Activities: ☐Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other _______________
Work Injuries: ☐Yes ☐No If yes:____
Sport Injuries: ☐Yes ☐No If yes:____
Falls: ☐Yes ☐No If yes: ____
Head Injuries: ☐Yes ☐No If yes:____
Dislocations: ☐Yes ☐No If yes: ____
Broken Bones ☐Yes ☐No If yes: ____
Surgeries ☐Yes ☐No If yes: ____

SOCIAL HISTORY & LIFESTYLE CHOICES

Alcohol	☐ None ☐ Light ☐ Moderate ☐ Heavy
Caffeine Drinks & Products	☐ None ☐ Light ☐ Moderate ☐ Heavy
Tobacco	☐ None ☐ Light ☐ Moderate ☐ Heavy
Recreational Drugs	☐ None ☐ Light ☐ Moderate ☐ Heavy
Soft Drinks	☐ None ☐ Light ☐ Moderate ☐ Heavy
Processed, Packaged & Restaurant Food	☐ None ☐ Light ☐ Moderate ☐ Heavy
Artificial Sweeteners	☐ None ☐ Light ☐ Moderate ☐ Heavy
Sleep	☐ None ☐ Light ☐ Moderate ☐ Heavy
Water	☐ None ☐ Light ☐ Moderate ☐ Heavy
Exercise	☐ None ☐ Light ☐ Moderate ☐ Heavy
Fresh & Homemade Foods	☐ None ☐ Light ☐ Moderate ☐ Heavy

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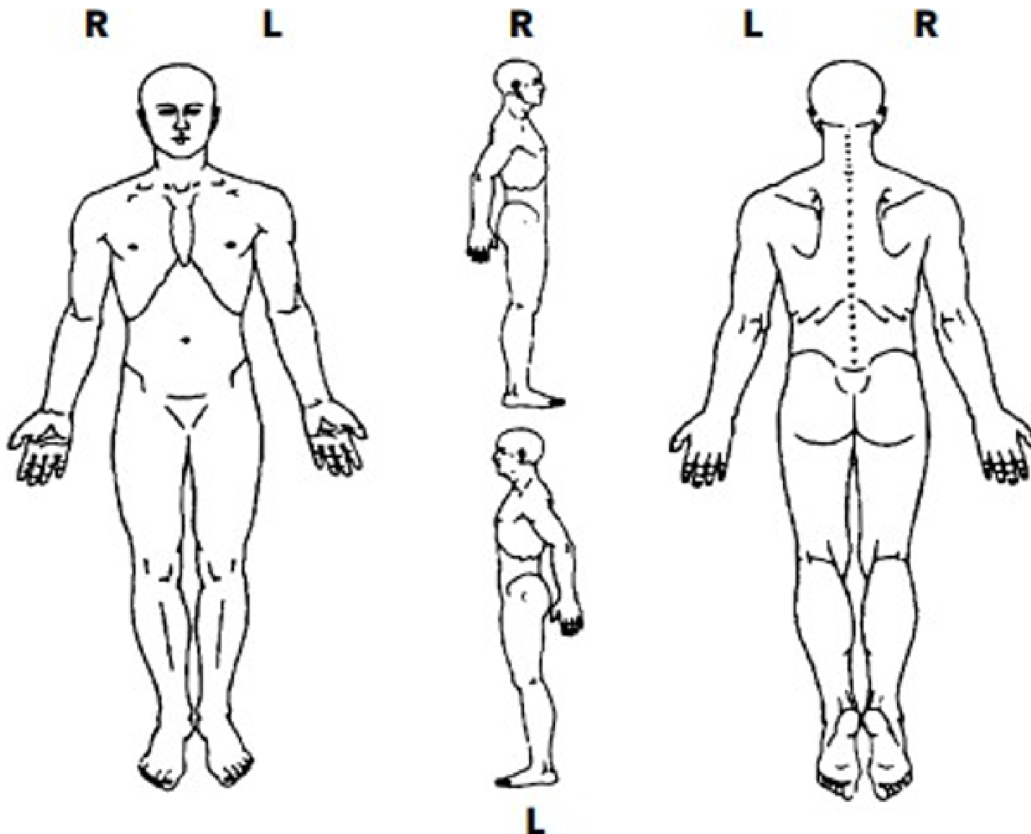
FAMILY HISTORY
Please indicate whether any biological members of your family have experienced any of the following:

☐Autoimmune Disease	☐ Diabetes	☐ Migraines	
☐Bleeding Disorder	☐ Heart Disease	☐ Osteoporosis	
☐ Clotting Disorder	☐ High Blood Pressure	☐ Stroke	
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease	☐Other: __________

CURRENT COMPLAINTS:
Please place an "X" in all locations where you are currently experiencing pain, discomfort, or other symptoms:



Primary complaint:
Please describe: ____
____
Date of symptom onset:___________
Cause of this complaint:_____________________________________
Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain (please circle):
…at its worst:(least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
…at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
…at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Achy ☐Shooting
☐Burning ☐Tingling ☐Crampy ☐Stiff ☐Swollen ☐Other_________
Does the pain travel from one location to another? ☐ Yes ☐No
If yes, from where to where?________________________________
How often do you experience this pain? ☐Constantly ☐Comes & goes ☐Infrequently
☐Daily ☐Weekly ☐Monthly
Is the pain/discomfort worse in the AM or PM? ☐AM ☐PM ☐N /A
Which activities are affected by this? ☐Working ☐Sleeping ☐Daily Routine ☐Exercising
☐Sitting ☐Standing ☐Walking ☐Bending
☐Lying Down ☐N/A ☐Other_________
Pain worsens with: ____
Pain improves with:____

Please list all treatments received for this complaint (PT, medication, acupuncture, chiropractic; etc):____

Please list any diagnostic tests that have been performed (X-ray, MRI, CT scan, lab tests, etc.) and results if known:__________________________________

Additional complaint(s):
Please describe: ____
____
Date of symptom onset:___________
Cause of this complaint:_____________________________________
Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain (please circle):
…at its worst:(least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
…at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
…at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numb ☐Achy ☐Shooting
☐Burning ☐Tingling ☐Crampy ☐Stiff ☐Swollen ☐Other_________
Does the pain travel from one location to another? ☐ Yes ☐No
If yes, from where to where?________________________________
How often do you experience this pain? ☐Constantly ☐Comes & goes ☐Infrequently
☐Daily ☐Weekly ☐Monthly
Is the pain/discomfort worse in the AM or PM? ☐AM ☐PM ☐N /A
Which activities are affected by this? ☐Working ☐Sleeping ☐Daily Routine ☐Exercising
☐Sitting ☐Standing ☐Walking ☐Bending
☐Lying Down ☐N/A ☐Other_________
Pain worsens with: ____
Pain improves with:____

Please list all treatments received for this complaint (PT, medication, acupuncture, chiropractic; etc):____

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FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: ______________________________ Date:______________

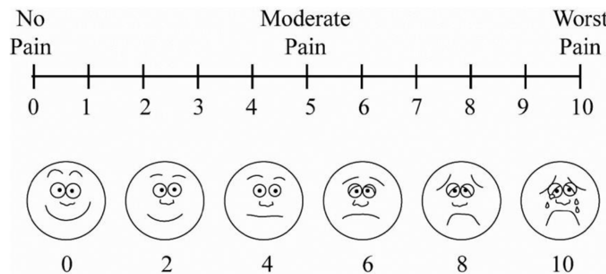
Directions: Please circle ONE answer per question that indicates your ability to perform the following activities. If the activity does not pertain to you, please place an “X” in the “N/A” column.

0=Unable **1**=Very Difficult **3**=Moderately Difficult **3**=Minimally Difficult **4**=Normal Function

Activity	Score					N/A
1. Sleep normally	0	1	2	3	4	
2. Grooming*	0	1	2	3	4	
3. Getting dressed	0	1	2	3	4	
4. Food Prep/Cooking/Eating	0	1	2	3	4	
5. Sitting for a normal** amount of time	0	1	2	3	4	
6. Standing for a normal** amount of time	0	1	2	3	4	
7. Walking	0	1	2	3	4	
8. Running/Jogging	0	1	2	3	4	
9. Up and down stairs	0	1	2	3	4	
10. Recreational/Sports activities	0	1	2	3	4	
11. Reaching above the head or across the body	0	1	2	3	4	
12. Squatting down to pick up an item	0	1	2	3	4	
13. Lifting/Carrying up to 10 lbs.	0	1	2	3	4	
14. Getting up/down from chair to bed (vice versa)	0	1	2	3	4	
15. Driving	0	1	2	3	4	
16. Perform all job requirements at work	0	1	2	3	4	

* = “Grooming” refers to oral care, hair brushing/combing, washing of the face and hands, shaving of the face, or applying make-up, if customary.
** = “Normal” is what you are accustomed to on a daily basis.

Using the pain scale below, circle the number that best describes the pain you have experienced at your worst.



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