CHRONIC CONDITIONS
CENTER OF GREENSBORO

403 Parkway, Suite A, Greensboro, NC 27401
336-285-7077

Welcome!

The following is information regarding your first visit at Chronic Conditions Center of Greensboro. **Your appointment has been scheduled under the assumption that your paperwork will have been completed prior to your appointment time.**
When filling out the, **Symptoms Survey form, please follow the directions carefully**. Mark the box "1" for **mild** symptoms, "2" for **moderate**, and "3" for **severe**. If the symptom does not apply to you, leave the box **blank**.

If you arrive without all of your paperwork completed, you will not been seen by the doctor. You will be asked to reschedule.

When you come in for your appointment, please:

- Bring your completed New Patient Paperwork (enclosed)
- Bring copies of previous x-ray's, MRI's, and lab results
- Please do not wear makeup or fingernail polish on your first visit (will inhibit exam results)
- Please do not chew gum
- Do not drink coffee within 2 hours of your appointment

Please note that our office does not file for your insurance. You may ask for a Superbill that you can submit to your insurance for re-imbursement. We look forward to working with you and re-establishing your health and wellness. If you have any questions, please give our office a call (336) 285-7077.

Kind Regards,
Chronic Condition Center Team

CHRONIC CONDITIONS
CENTER OF GREENSBORO

Your Wellness History—Intake Form

Welcome to Chronic Conditions Center of Greensboro. Please be completely accurate and answer each question. Your answers to the following questions are the first step in determining your immediate and long term health care needs. Please elaborate on any question or add any comments you have…the more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank you!

Personal Information

Full name:	**Date:**
Address:	
City:	**State:** **Zip Code:**
Primary phone:	**Work phone:**
Email address:	
Date of birth:	**Age:**
No. of children:	**Pregnant?** **Yes** ☐ **No** ☐
Height:	**Weight:**
Marital status: **M S W D**	**Spouse/guardian name:**
Your Occupation:	
Employer's name:	
Spouse's Occupation/Employer:	
Emergency Contact:	**Phone:**
Relationship to you:	

Whom may we thank for referring you, or how did you hear about us?_____

What is your primary reason for seeking treatment today? _____
_____

Addressing What Brought You Into This Office: *If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".*

Health Challenges (including your pain)

Please list your health challenges according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury? Or something else?	% of the time pain is present

1.					
2.					
3.					

What type of pain do you feel (Circle all that apply):
Sharp * Dull * Achy * Throbbing * Tingling * Numb * Cramping * Burning * Stiffness * Tightness * Stabbing * Shooting * Electric
Other_____

Does the problem move/radiate to other body parts? If so, where?
Arm * Hands * Buttocks * Thigh * Calf * Feet * Ribs * Abdomen * Chest * Head * Neck * Groin
Other_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

Which activities make your condition feel worse (Circle all that apply)?
* Sitting * Standing * Walking * Lifting * Bending * Twisting * Working * Exercising/gentle exercise * Stairs * Lying Down *
Other_____

Is this condition interfering with any of the following (*CIRCLE ALL THAT APPLY*):
*Work *Sleep *Sports/Exercise *Daily Routine *Playing w/Children *Bathing *Running *Housework *Yard work *Hobbies *Lifting
*Eating *Dressing *Grooming *Standing *Sitting *Lying down *Sex *Walking
*Other (please explain) _____

What offers relief for this condition?
Tylenol * Advil * Aleve * Prescription Drugs * Icy hot * Heat * Ice * Stretching * Exercise * Rest * Movement * Massage
Standing * Sitting *Lying down * Home Remedies * Physical Therapy * Surgery
*Other _____

Is there a time of day when your pain is worse or better:_____

Have you ever had x-rays taken for this condition?

Area of body:	When?	Where?

Other doctors you have seen for this condition:

Name:	Address:
When did you see them?	

Name:	Address:
When did you see them?	
What was your diagnosis?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc?
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When:	Doctor:
2. Type:	When:	Doctor:

3. Type:	When:	Doctor:

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When:	Hospitalized: Yes ☐ No ☐
2. Type:	When:	Hospitalized: Yes ☐ No ☐
3. Type:	When:	Hospitalized: Yes ☐ No ☐

Any details about these injuries you would like to elaborate upon:_____

_____

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

_____

Lifestyle factors over a long period of time often affect our health in ways that we may not even be aware of. Please take special care to answer the following questions carefully. Thank you.

Diet **--------** Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee/black tea	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables	Fast Food	Candy	Bread

How much water do you typically drink in a day: _____

The type of diet I usually follow is classified as: _____

Please list any allergies: _____

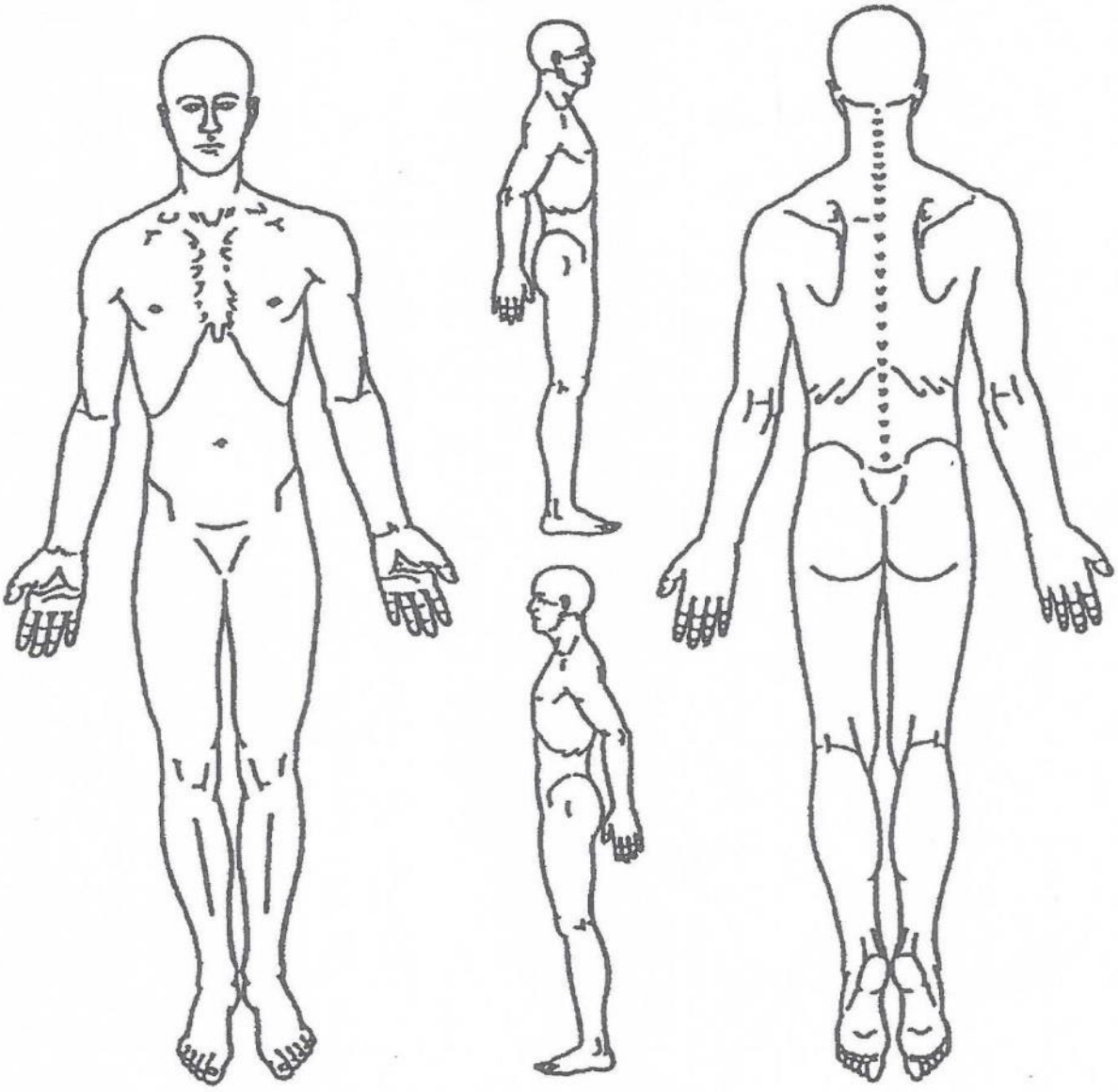
Please list any food sensitivities: _____

Please list any food cravings that you have: _____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Nutritec Software Symptom Survey

NAME: _____ DATE: _____

Phone: _____ E-mail: _____

Fax: _____ DOB: ____/____/____

Sex: ☐ Male ☐ Female Tissue Calcium:_____

Height : _____ Weight : _____

Blood Pressure: Pulse:____

Sitting:_____ Laying:_____ Standing:_____

INSTRTIONS: Completely black out one of the three circles: 1-mild, 2-moderate, 3-severe

● ○ ○ **MILD** symptoms (once or twice last 6 months)
○ ● ○ **MODERATE** symptoms (once or twice last month)
○ ○ ● **SEVERE** symptoms (Chronic, once or twice last week)
○ ○ ○ Leave circles **BLANK** if they do not apply to you!

	1	2	3	
				---------- GROUP 1 ----------
1	○	○	○	Acid foods upset
2	○	○	○	Feel chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meals
6	○	○	○	Keyed up; unable to feel calm
7	○	○	○	Cuts heal slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold and/or clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Body temperature rises easily
18	○	○	○	Skin sensitive to touch
19	○	○	○	Staring, blinks little
20	○	○	○	Frequently has a sour stomach
				---------- GROUP 2 ----------
21	○	○	○	Joint stiffness after rising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen or puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; "lightheaded" often
29	○	○	○	Food digests rapidly
30	○	○	○	Vomit frequently
31	○	○	○	Frequently hoarse
32	○	○	○	Irregular breathing
33	○	○	○	Pulse slow or feels "irregular"
34	○	○	○	Slow gag reflex
35	○	○	○	Difficulty swallowing
36	○	○	○	Alternating constipation and diarrhea
37	○	○	○	"Slow starter"
38	○	○	○	Not easily chilled
39	○	○	○	Perspire easily
40	○	○	○	Poor circulation or sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				---------- GROUP 3 ----------
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetitie

	1	2	3	
				---------- GROUP 3 continued ----------
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Feeling fatigued, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Upset feeling from excessive eating of sweets
52	○	○	○	Awaken after few hours sleep hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				---------- GROUP 4 ----------
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	Discomfort at high altitude
60	○	○	○	Opens windows in closed room
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon yawner
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles worse at night
65	○	○	○	Muscle cramps, worse during exercise; "charley-horse"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily,"black/blue"spots on arms or legs
69	○	○	○	Tendency to anemia
70	○	○	○	Frequently have "nose bleeds"
71	○	○	○	"Ringing in ears" or noises in head
72	○	○	○	Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion
				---------- GROUP 5 ----------
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter or metallic taste in mouth in the mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Feelings of worry, dread, or insecurity
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upsets
85	○	○	○	Stools light-colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Using laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmares/bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				---------- GROUP 6 ----------
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul smelling gas
103	○	○	○	Indigestion 1/2-1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucus colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

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	1	2	3	
				---------- GROUP 7A ----------
107	○	○	○	Insomnia
108	○	○	○	Nervousness
109	○	○	○	Can't gain weight
110	○	○	○	Intolerance to heat
111	○	○	○	Highly emotional
112	○	○	○	Flush easily
113	○	○	○	Night sweats
114	○	○	○	Skin is thin and moist
115	○	○	○	Inward trembling
116	○	○	○	Heart palpitates
117	○	○	○	Increased appetite without weight gain
118	○	○	○	Pulse races when resting
119	○	○	○	Eyelids and face twitch
120	○	○	○	Irritable and restless
121	○	○	○	Can't work under pressure
				---------- GROUP 7B ----------
122	○	○	○	Noticeable weight gain
123	○	○	○	Decrease in appetite
124	○	○	○	Easily fatigued
125	○	○	○	Ringing in ears
126	○	○	○	Sleepy during day
127	○	○	○	Sensitive to cold
128	○	○	○	Dry or scaly skin
129	○	○	○	Constipation
130	○	○	○	Mental sluggishness
131	○	○	○	Hair coarse, falls out
132	○	○	○	Headaches upon arising wear off during day
133	○	○	○	Pulse slow, below 65
134	○	○	○	Frequent urination
135	○	○	○	Impaired hearing
136	○	○	○	Reduced initiative
				---------- GROUP 7C ----------
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance
				---------- GROUP 7D ----------
142	○	○	○	Abnormal thirst
143	○	○	○	Bloating of the abdomen
144	○	○	○	Weight gain around hips or waist
145	○	○	○	Sex drive reduced or lacking
146	○	○	○	Tendency toward ulcers and/or colitis
147	○	○	○	Increased sugar tolerance
148	○	○	○	(FEMALE) Menstrual disorders
149	○	○	○	(YOUNG GIRLS) Lack of menstrual function
				---------- GROUP 7E ----------
150	○	○	○	Dizziness
151	○	○	○	Headaches
152	○	○	○	Hot flashes
153	○	○	○	Increased blood pressure
154	○	○	○	(FEMALE) Hair growth on face or body
155	○	○	○	Sugar in urine (not diabetes)
156	○	○	○	(FEMALE) Masculine tendencies
				---------- GROUP 7F ----------
157	○	○	○	Weakness and/or dizziness
158	○	○	○	Chronic fatigue
159	○	○	○	Low blood pressure
160	○	○	○	Nails weak and/or ridged
161	○	○	○	Tendency towards hives
162	○	○	○	Arthritic tendencies
163	○	○	○	Perspiration increase
164	○	○	○	Bowel disorders
165	○	○	○	Poor circulation
166	○	○	○	Swollen ankles
167	○	○	○	Crave salt
168	○	○	○	Brown spots or bronzing of skin
169	○	○	○	Allergies - tendency to asthma
170	○	○	○	Weakness after colds or influenza
171	○	○	○	Muscular and nervous exhaustion
172	○	○	○	Respiratory disorders

	1	2	3	
				---------- GROUP 8 ----------
173	○	○	○	Apprehension
174	○	○	○	Irritability
175	○	○	○	Morbid fears
176	○	○	○	Never seems to get well
177	○	○	○	Forgetfulness
178	○	○	○	Indigestion
179	○	○	○	Poor appetite
180	○	○	○	Craving for sweets
181	○	○	○	Muscular soreness
182	○	○	○	Depression; feelings of dread
183	○	○	○	Noise sensitivity
184	○	○	○	Acoustic hallucinations
185	○	○	○	Tendency to cry without reason
186	○	○	○	Hair is coarse and/or thinning
187	○	○	○	Weakness
188	○	○	○	Fatigue
189	○	○	○	Skin sensitive to touch
190	○	○	○	Tendency towards hives
191	○	○	○	Nervousness
192	○	○	○	Headache
193	○	○	○	Insomnia
194	○	○	○	Anxiety
195	○	○	○	Anorexia
196	○	○	○	Inability to concentrate; confusion
197	○	○	○	Frequent stuffy nose; sinus infections
198	○	○	○	Allergy to some foods
199	○	○	○	Loose joints
				---------- FEMALE ONLY ----------
200	○	○	○	Very easily fatigued
201	○	○	○	Premenstrual tension
202	○	○	○	Painful menses
203	○	○	○	Depressed feelings before menstruation
204	○	○	○	Excessive and prolonged menstruation
205	○	○	○	Painful breasts
206	○	○	○	Menstruate too frequently
207	○	○	○	Vaginal discharge
208	○	○	○	Hysterectomy / ovaries removed
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Long standing depression
				---------- MALE ONLY ----------
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Frequent night-time urination
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Too easily tired
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

List below your five main physical complaints in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Notes:

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. **Physical stress (falls, accidents, work postures, work injuries, sports injuries, repetitive work postures, etc.)**
   a. _____
   b. _____
   c. _____

2. **Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, medications, drugs/alcohol, etc.)**
   a. _____
   b. _____
   c. _____

3. **Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)**
   a. _____
   b. _____
   c. _____

Have you ever suffered from an addiction of any sort: _____

Have you ever had psychotherapy or counseling? ☐Yes ☐No

☐Currently being seen ☐Previously If Previously, from _____ to _____

What kind of counseling? _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) **please describe your:**

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health:

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health:

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

For Women:

Date of last PAP_____ Bone Density Scan_____ Mammogram_____
Age of 1st period (menarche)_____ Age of last period (Menopause)_____

For Men:

Date of last prostate checkup_____ PSA results_____ Manual prostate exam results_____
Lab results_____

For everyone: **Have you had or do you have the following sexually transmitted OR contagious diseases:** (Please circle all that apply)
*Hepatitis * Tuberculosis * Aids * Herpes * Gonorrhea * Syphilis *HPV *Chlamydia *Herpes 0ther_____

Family Health History

Does any member of your family have or have had any of the following health conditions:

Diabetes * Heart Disease * Kidney Disease * Cancer * Thyroid Disease * Hypertension * Other

Mother: _____

Father: _____

Sibling: _____

Other: _____

Do you have, or have you had any of the following:

Stomach Disorder ___No ___Yes Hiatal Hernia ____ Heartburn ____ Stomach Stapled____ Other_____
Heart Disease: ___No ___Yes If yes, describe _____
High Blood Pressure: ___No ___Yes If yes, list medications _____
Cancer: Where? _____High Cholesterol/Triglycerides_____
Diabetes: ___No ___Yes If yes, how is it controlled? _____
Thyroid Disease: ___No ___Yes If yes, describe:_____

Have you had any of the following diseases: (Circle all that apply) Anemia Rheumatic Fever Epilepsy Influenza Appendicitis Pneumonia Mumps Pleurisy Measles Whooping Cough Polio Chicken Pox Mental Disorder

What other health or medical challenges/issues do you have:_____

Have you had any of the following organs/glands removed: Gallbladder Uterus or Ovaries Appendix Thyroid Tonsils & Adenoids Any other body part removed:_____

Have you ever been treated by a chiropractor, acupuncturist or holistic health practitioner?

_____

Please list other problems or concerns you have or had:

_____

_____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would you help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Is there anything else which may help to better understand your condition which has not been discussed?

_____

_____

History of Chief Concern: Please provide an outline of your past experience in treating your primary concern. Note any diagnoses, tests done to confirm the diagnosis, treatments and your response to those treatments. Please include specific therapies done and your response to them. What are your thoughts about the treatments and the outcome? This is only an outline and does not need to be exhaustive as we will discuss during your appointment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I have reviewed this information on the questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used to determine appropriate and healthful treatment. If there is a change in my medical status, I will inform my treating physician.

*Signature*_____ *Date* _____

CHRONIC CONDITIONS CENTER OF GREENSBORO OFFICE POLICIES

******Please read all of these thoroughly before signing******

1. PAYMENT IS DUE IN FULL WHEN SERVICES ARE RENDERED. PRE-PAYMENTS AND PAYMENT PLANS MAY BE ACCEPTED ON A CASE-BY-CASE BASIS. A general schedule of services and fees are available by inquiring at the front desk. Payments can be made by cash, check, debit card, credit card, health savings, or flex spending accounts.
2. In the event that a patient's account is delinquent, an overdue notice will be sent his/her address on file. If payment is not received within 30 days of the notice date, a 1.5% per month service charge will be incurred until paid in full.
3. Products purchased from this office are 100% REFUNDABLE within 7 days if the products are returned unopened and in good condition.
4. There will be an additional $25 fee for returned or NSF checks.
7. This office is not in network with any insurance company nor will we submit any insurance claim for you. You may ask for a Superbill to submit to your insurance for re-imbursement. If you have an HSA account, most often you may use your flex spending card to pay for your services.
8. It is not this office's obligation to enter into a dispute with an insurance company concerning payment.
9. If 6 months or more lapse between a patient's treatments, the next appointment scheduled will automatically be a re-examination,which incurs an additional fee.
10. Nutrition consultations, exercise consults or supplement charges are due at the time of service. These are cash services, not covered by any insurance or third party payors.
11. Laboratory testing (varies by company) may or may not be covered by your insurance.
12. Medicare covers spinal adjustments only in an acute injury and <u>does not</u> cover any exams, x-rays, re-exams, modalities, extremity adjustments, supports or supplements. If you receive any of these non-covered services or supplements, <u>it is your responsibility to pay the</u> complete cost at the time received. Medicare also doesn't cover Maintenance or Wellness care. If you choose these services, these are paid out of pocket at the Medicare rate.

Patient Missed Appointment Policy

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results.
If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in your life so that this can occur.

2. Our office strives to run on time as much as possible. If you are more than 5 minutes late for an appointment, you may be asked to reschedule.

2. If you become ill, we oftentimes want you to come in, because your treatment will help you recover, so please ask the front desk about your illness and if you should come in for treatment.

3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment

4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change an appointment.

5. If you choose to not finish your entire treatments for the day, they will be counted as completed. The only exception is made if the office is not able to accommodate your therapies in an adequate time frame during the scheduled therapy time.

5. Service charges for missing an appointment or cancelling without 24 hour notice are as follows:

15 minute Chiropractic appointment $45
30 minute Chiropractic appointment $60

Chronic Care Packages:
1 warning and then 1 treatment will be deducted

**Note: Text reminders are made the day before each patient's appointment. These texts are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a confirmation text does NOT validate a missed appointment.*

I have read and understand the above policy
Patient's Name: _____
Signature: _____
Witness: _____

CHRONIC CONDITIONS CENTER OF GREENSORO
403 Parkway, Suite A
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336-285-7077

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Center for Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the complete Notice of Privacy Practices for more description of how your Protected Health Information 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. You may request a copy of the Notice at the Front Desk. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Our Privacy Pledge
We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information at any time.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- 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 Protected Health Information. 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. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date