1941 Savage Rd, Suite 300D
Charleston, SC 29407
O: 843-852-4141
F: 843-793-2952
info@charlestonchirostudio.com

Application for Care at Charleston Chiropractic Studio

Patient Information

Name_____ Birth Date_____/_____/_____ _ Male _ Female
Today's Date_____ Home Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone _____ SSN#_____
Email_____ Employer_____
Occupation:_____ Hours/wk _____ How long at this position?_____
Married? _ Yes _ No Name of Spouse_____ Spouse's Date of Birth____/____/____
Names and Ages of your children: _____
How did you hear about us? _____Person Responsible for this account_____
Primary Medical Insurance [Present card(s) to staff]_____
Do you consent to receive automated communication? _ Yes _ No

History Of Complaint

Please identify the reason/ complaint(s), injury or illnesses that brought you to this office:
_____
When did this problem(s) begin? _____
Is your problem the result of ANY accident? _Yes _ No Date of Accident: ____/_____/_____
If yes identify type: _Auto _Work _Home _Other (please explain):_____
Have you suffered from the same or similar problem(s) in the past? _ Yes _ No
If yes when? _____Who provided the treatment:_____
Please state what they said or recommended:_____
What were the results? _Favorable _ Unfavorable
Is this condition progressively getting worse? _ Yes _ No _ Unknown
What % of the day do you experience your symptoms: _Constant _Frequent _Intermittent
Are your symptoms worse in the: _A.M _ P.M. _consistent all day no change
Does it interfere with your: _Work _Sleep _Daily routine _ Recreation
What makes it worse? _Bending _Walking _Exercising _Sitting _Other: _____
Describe your activities at work:_____
Have you ever had chiropractic care? _ Yes _ No Name of Chiropractor: _____
If yes how long were you under care: _____ What were the results? _____
Are you taking medication(s) for complaint(s): Muscle relaxers / Pain killers /Over-the-counter_____

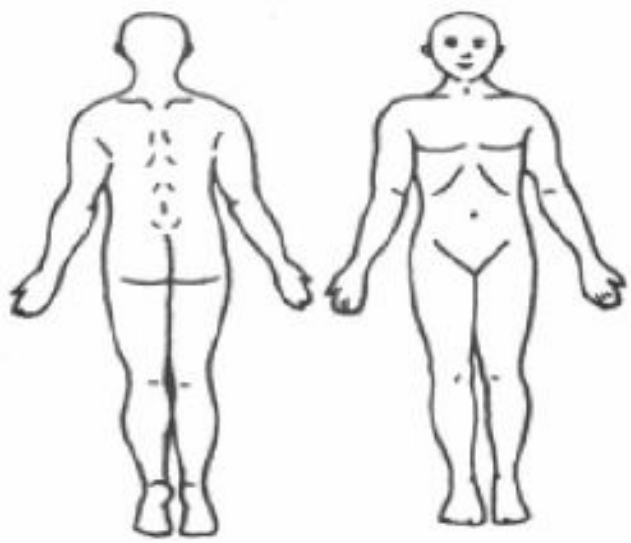
I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or staff responsible for any errors or omissions that I may have made in the this form.

Patient Signature	Date	Reviewed By	Date

History Of Complaint & Other Systems

*Please mark the areas on the Diagram below with the following letters to describe your symptoms. Also Feel free to write any relative notes/drawings

R =Radiating B =Burning D =Dull A =Aching N =Numbness S =Sharp/Stabbing T =Tingling



*Please circle any symptoms you currently have or have had in the past

NECK	Left	Right	**ARMS & HANDS**	Left	Right
Pain in neck	L	R	Pain in upper arm	L	R
Neck stiffness	L	R	Pain in elbow	L	R
Neck weakness	L	R	Pain in forearm	L	R
Pinched nerve	L	R	Pain in hand	L	R
Neck feels out of place	L	R	Pain in fingers	L	R
Muscle spams	L	R	Pins & needles arm	L	R
Grinding/popping	L	R	Pins & needles fingers	L	R
MID - BACK			Numbness in arm	L	R
Mid-back pain	L	R	Numbness in fingers	L	R
Mid-back stiffness	L	R	Weakness in arm	L	R
Pain between shoulder blades	L	R	Weakness in hand	L	R
Pain under shoulder blade	L	R	Cold Hands	L	R
Pain from front to back	L	R			
Muscle spasms	L	R			
LOW BACK			**HIPS, LEGS & FEET**		
Low back pain	L	R	Pain in buttocks	L	R
Low back stiffness	L	R	Pain in hip joint	L	R
Low back weakness	L	R	Pain down leg	L	R
Pinched nerve in low back	L	R	Pain in knee	L	R
Low back feels out of place	L	R	Pain in ankle	L	R
Muscle spasms	L	R	Pain in foot	L	R
Low back feels unstable	L	R	Weakness leg/cramps	L	R

_____ _____ _____ _____

Patient Signature | Date | Reviewed By | Date

General Systems

*Please circle any symptoms you have or have had in the past

GENERAL	APPETITE	EAR,EYE,NOSE,THROAT	MEN Only	GENITO URINARY
Bruise easily	Bloating	Bleeding gums	Breast lump	Blood in urine
Chills	Bowel Changes	Blurred vision	Erection difficulties	Frequent urination
Dental Problems	Constipation	Crossed eyes	Lump in testicles	Lack of bladder control
Depression	Diarrhea	Difficulty Swallowing	Cancer	Painful urination
Difficulty Sleeping	Excessive hunger	Double vision		
Dizziness	Excessive thirst	Earache		**CARDIOVASCULAR**
Fainting	Gas	Ear discharge		Chest pain
Fever	Hemorrhoids	Hay fever	**WOMEN only**	High blood pressure
Forgetfulness	Indigestion	Hoarseness	Abnormal pap smear	Irregular heart beat
Headache	Nausea	Loss of hearing	Bleeding b/w periods	Low blood pressure
Loss of Sleep	Rectal Bleeding	Nosebleeds	Breast lump	Poor ciruclation
Loss of Weight	Stomach pain	Persistent cough	Extreme menstrual pain	Rapid heart beat
Nervousness	Vomiting	Ringing in ears	Hot flashes	Swollen ankles
Numbness	Vomiting blood	Sinus problems	Nipple discharge	Varicose veins
Sweats	Ulcer	Vision-flashes	Painful intercourse	
Tiredness		Vision-halos	Vaginal discharge	**SKIN**
Weight Gain			Other	Bruise easily
				Hives
				Itching
				Change in moles
				Rash
				Sore that won't heal

Date of last menstual period: _____

Date of last mammogram: _____

Other complaints: _____

Conditions/Past History

*Please circle any conditions you currently had or have had in the past

Aids	Cataracts	Hepatitis	Mumps	Suicide Attempt
Alcohoholism	Chemical Dependancy	Hernia	Osteoporosis	Thyroid Problem
Anemia	Chicken Pox	Herpes	Pacemaker	Tonsilitis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Tumors & Growth
Appendicitis	Emphysema	HIV Positive	Polio	Typhoid Fever
Arthritis	Epilepsy	Kidney Disease	Prostate Problem	Ulcers
Asthma	Fractures	Liver Disease	Prostesis	Vaginal Infections
Blood Disorders	Glaucoma	Measles	Phsyciatric Care	Venereal Disease
Breast Lump	Goiter	Migraine Headaches	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Miscarriage	Rheumatic Fever	Other _____
Bulimia	Gout	Mononucleosis	Scarlet Fever	_____
Cancer	Heart Disease	Multiple Sclerosis	Stroke	_____

_____ _____ _____ _____

Patient Signature | Date | Reviewed By | Date

Functional Questionnaire

Please Circle the Appropriate Number for each Activity that Applies.
(0)No Pain, (1)Very Mild Pain, (2)Mild Pain, (3)Very Tolerable Pain, (4)Tolerable Pain, (5)Somewhat Moderate Pain, (6)Moderate Pain, (7)Moderate-Severe Pain, (8)Severe Pain, (9)Very Severe Pain, (10)Disabling Pain

Walking	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Sit to Stand	0	1	2	3	4	5	6	7	8	9	10
Bending	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Pushing	0	1	2	3	4	5	6	7	8	9	10
Extended Computer Use	0	1	2	3	4	5	6	7	8	9	10
Household Chores	0	1	2	3	4	5	6	7	8	9	10
Working	0	1	2	3	4	5	6	7	8	9	10
Reading/Concentrating	0	1	2	3	4	5	6	7	8	9	10
Self Care - Bathing	0	1	2	3	4	5	6	7	8	9	10
Self Care - Dressing	0	1	2	3	4	5	6	7	8	9	10
Exercise/Recreation	0	1	2	3	4	5	6	7	8	9	10
Gardening	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Rolling Over	0	1	2	3	4	5	6	7	8	9	10
Watching TV	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Climbing Stairs	0	1	2	3	4	5	6	7	8	9	10

On scale of 1-10, 10 being the highest, rate your commitment to getting rid of the problem: _____

Please list any concerns that might interfere with your commitment (transportation, time, finances, Other, etc): _____

_____

_____

_____

_____

_____ _____ _____ _____

Patient Signature | Date | Reviewed By | Date

Medications/ Vitamins

Medications	Vitamins/ Supplements/ Herbs
Allergies:_____	

Social History

1. Smoking: _cigars _pipe _cigarettes _Daily _Weekends _Occasionally _Never
2. Alcoholic Beverage consumption: _Daily _Weekends _Occasionally _Never
3. Recreational Drug use: _Daily _Weekends _Occasionally _Never
4. Soda/Pop consumption: _Daily _Weekends _Occasionally _Never

Family History

1. Does anyone in your family suffer with the same condition(s) you have? _No _Yes
   If yes whom: _grandmother _grandfather _mother _father _sister _brother _child

2. Have they ever been treated for their condition? _Yes _No _I don't know

3. List other hereditary conditions the doctor should be aware of:_____

I hereby authorize payment to be made directly to Charleston Chiropractic Studio for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Charleston Chiropractic Studio.

_____ _____ _____ _____
Patient Signature Date Reviewed By Date

Notice of HIPPAA Privacy Practice

Charleston Chiropractic Studio is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. For payment purposes - to obtain payment from your insurance company or any available collateral source.
3. For workers compensation purposes- to process a claim or aid in investigation.
4. Emergency- in the event of a medical emergency we may notify a family member.
5. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
7. For military, national security, prisoner and government benefits purposes.
8. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
9. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
10. Spouses, household partners and other close family members.
11. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call the office at 843-852-4141. If unavailable, you may make an appointment with our receptionist to see your doctor within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: South Carolina Department of Labor, Licensing and Regulation at Contact.Chiro@llr.sc.gov or call 803-896-4587

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Charleston Chiropractic Studio Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Signature	Date	Reviewed By	Date

Charleston Chiropractic Studio Office Policies

_**PATIENT PRIVACY:** All information shared with your doctor will remain confidential between you and your doctor. If you would like to share your records with anyone else, you must sigh a Release of Records consent form.

_**YOUR CARE:** When a patient seeks chiropractic care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care is rendered primarily to correct vertebral subluxations. The doctors use a specific, hands-on technique to accomplish this goal, including Gonstead and Diversified Technique. Your doctor will outline a care plan that will take you beyond simple pain relief. Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostic may also be ordered to confirm the true nature and exact location of subluxations. The exam is mandoatory to assist the doctor in determining chiropractic amenability, as well as the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do to maintain their health for a lifetime.

_**PATIENT WORKSHOPS:** To enhance your understanding health and chiropractic, you will be recommended to attend our health workshops. They are free of charge and will help you move closer towards your health goals.

_**REFERRING TO SPECIALTY PROVIDERS:** We do not offer to diagnose or treat any diseases or condition other than vertebral subluxations. If during the course of your spinal examination, the doctor discovers an unrelated problem, you will be advised to seek a consultation with another specialty provider.

_**FREQUENCY AND DURATION OF CARE Adults:** While pain relief may take only a few visits, getting well takes time. Generally speaking, a patient's age and life style along with the severity of the accompanying symptoms and the length of time the condition has existed will play a large role in determining the frequencies and duration of their care. The longer the subluxation has existed the more damage and the longer it will take to achieve correction. **Children:** Young spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxations; therefore, it is best to check children for subluxations and begin any necessary care as young as infancy.

_**CARE PLAN INTERRUPTIONS:** In order to complete your first phase of care in the least amount of time with maximum results, it is vital that you follow the recommended care outlined by your doctor without exception. That means if you miss an appointment, you must reschedule that appointment for the same or next day. If you are going on vacation or out of town for an extended period of time please let the doctor know so we can work around it.

_**YOUR CHIROPRACTOR:** Chiropractors are required to attend continuing education classes for license renewal every year. Additionally Dr. Ruettiger may be called out of town to a conference. Although Dr. Ruettiger will not be available to adjust patients during his/her absence another qualified doctor, familiar with your case will be managing your care until the doctor returns. It is our policy to ensure all active patients receive a continuum or uninterrupted care.

_**DISCONTINUING CARE:** Should you decide to discontinue care in this office, you must speak to Dr. Ruettiger directly so that an appropriate assessment as to the status of your health that day can be made and documented in your record. This is particularly important if the patient should be injured in an accident in the future and a baseline for liability becomes necessary. Additionally, if you have a credit on your account and would like a refund it is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days of discontinuing.

_**HOLIDAYS/AFTER HOURS:** The office will give you plenty of notice on holiday closures. Given emergencies, the doctos are more than willing to see you. Please contact your doctor immediately in this case.

¯**CAR ACCIDENT:** If you are involved in an accident or personal injury, the doctors will open a new case for you. Please provide the office with all relevant claim information.

_**FEES & PAYMENT FOR SERVICES:** Fees for services are due at the time services are rendered. We have two options for patients to make payment. 1. Prepay balance in full; 2. Monthly payments. We accept check, cash, credit card or Med Choice. If you have network insurance and are receiving wellness treatment, you acknowledge that your insurance does not cover your wellness treatment and you instruct us to not bill your insurance.

_**BILLING INSURANCE:** We ask our patients to please understand that health and accident insurance policies are a contract between them and their insurance company. We are happy to assist our patients in filing claims for reimbursement and will accept any amounts authorized by a patient to be paid directly to Charleston Chiropractic Studio. However, it must be clearly understood that all services rendered are charged directly to the patient and that patients are intimately, personally responsible for payment.

_ **CARING FOR YOUR FAMILY:** It is the policy of this practice to offer the families of all new patients the opportunity to be evaluated. The office offers family care plans to make care more affordable. Please inquire for more info.

_**CONSULTATIONS:** It is the policy of this practice to offer complimentary consultations to first time new patients.

Patient Signature	Date	Reviewed By	Date

Medicare Policy

Charleston Chiropractic Studio, LLC IS A NON-PARTICIPATING PROVIDER

This means that we have do not accept assignment and do not receive payment from Medicare for those services considered eligible by Medicare for reimbursement.

We can still bill your services to Medicare If you wish, however please be aware that Medicare will not cover any of the cost and you are expected to follow Charleston Chiropractic Studio's financial policies to make payment.

At this time Medicare's chiropractic coverage is limited to non-wellness manual manipulation of the spine. No other services will be paid for by Medicare. Before Medicare will consider reimbursement of a spinal manipulation, the doctor must verify the existence of a subluxation. Subluxations are demonstrated through the use of plain film radiography or performance of a specific examination. Because neither of these services are eligible for Medicare reimbursement it is the policy of this practice to collect those fees at the time of service, from the Medicare beneficiary. Finally, Medicare does not impose a limit on the amount of chiropractic care that a beneficiary may receive per say, however they do routinely audit providers practices to ensure a very strict "Medical Necessity" Policy. This means that a Medicare patient's Chiropractic Care is only eligible for reimbursement if there is evidence of a significant health condition that presents with active symptoms, and it is reasonable to expect that the care rendered will bring about considerable improvement in the patient's condition so that full function is restored within a relatively short and predictable period. When patients have achieved maximum clinical improvement, care aimed at maintaining or preserving a level of achieved functionality, or to prevent regression, or promote and enhance a quality of life will not be paid for by Medicare.

I understand that Charleston Chiropractic Clinic does not participate in Medicare. This means that I am responsible to pay all fees for all services rendered at Charleston Chiropractic Clinic.

Patients' Name :_____ DOB: _____

_____ _____ _____ _____

Patient Signature | Date | Reviewed By | Date

1941 Savage Rd, Suite 300D
Charleston, SC 29407
PH: 843-852-4141
info@charlestonchirostudio.com

Release of Information

I_____ give Charleston Chiropractic Studio permission to use my name, my photo, and my personal chiropractic testimonial for marketing purposes, office branding, and on social media including but not limited to: Facebook, Twitter, Pinterest, Instagram, YouTube, etc. Charleston Chiropractic Studio can also use my name and/or photo and/or testimonial for marketing or social proof purposes in the office on the referral board, testimonial book, etc. I give ongoing consent to the aforementioned requests until I request that my name and/or testimonial be no longer available to the public.

Signature:_____ Date:_____

Office Representative Signature:_____ Date:_____

_____	_____	_____	_____
Patient Signature	Date	Reviewed By	Date