



Healing Hands Chiropractic Family Wellness Center

An Integrative Approach To Optimal Health

Patient Registration Form

We offer a unique service to individuals and families. We are happy you have chosen to use our services. We will make every effort to make your experience supportive, informative and healing. Please complete the following:

Name _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Marital Status S M W D
Occupation _____ Employer _____
Business Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ SSN _____
Spouse's Name _____ Spouse's Occupation _____
Name & Ages of Children _____

Previous chiropractic care (please circle one) Y N With Whom _____
How Long _____ Date of Last Visit _____
Why did you stop care? _____
Reason for consulting this office _____
How did you learn about our office _____

Hobbies _____

Signature _____ Date _____

The mission of Healing Hands Chiropractic is to promote the overall health, well being and the highest quality of care of life of all patients through natural chiropractic care.



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Confidential Health Entrance Form

Full Name _____

Date _____

Please list reasons below for pursuing chiropractic care today:

Primary Reason:

Secondary Reason(s):

In order for us to better understand your current level of health, please circle any of the body signals which you have or have had previously:

Allergies	Depression	Infertility	Scoliosis
Anxiety	Dizziness	Irritable Bowel Syndrome (IBS)	Sinus Problems
Arthritis	Ear Infections	Latching issues	Stress Relief
Asthma	Frequent Cold/ Flu	Menstrual/ Menopausal Issues	TMJ Problems
Back Pain	Headaches	Numbness and Tingling	Torticollis
Body Image Problems	Heartburn	Poor Posture	Pregnancy
Colic	High Cholesterol	Reflux	Breech Baby
	Hip Pain/ Leg Pain	Sciatica	Other _____

Please circle the following conditions that you have or have had:

Alcoholism	Epilepsy	Hyper/Hypothyroidism	Scoliosis
Cancer	Heart Disease	Lung Disease	Stroke
Diabetes	High Cholesterol	Multiple Sclerosis	Ulcers
	HIV		Other _____

Please circle the conditions that are common to your family members:

Alcoholism	Epilepsy	Hyper/Hypothyroidism	Scoliosis
Cancer	Heart Disease	Lung Disease	Stroke
Diabetes	High Cholesterol	Multiple Sclerosis	Ulcers
	HIV		Other _____

Please list the prescription, OTC medications or vitamins/supplements you are currently taking:

Signature _____

Date _____

156 Harvey Rd. STE 2 Londonderry, NH 03053 | 603-434-3456 | www.HealingHandsNH.com



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Policies for Patient Conduct

Late appointments

When you schedule an appointment, that time is reserved for you and, therefore, not available to others who are waiting for services.

If you will be late to an appointment, we request that you notify us by calling the office at (603)434-3456. If you will be more than 5 minutes late for your appointment, we will make every effort to accommodate you. However, you may be asked to reschedule your appointment.

Missed appointments

If you do not arrive for a scheduled chiropractic appointment, and do not contact the office more than 24 hours prior to your scheduled appointment time, you will be charged a fee for the missed appointment for each person scheduled.

In the unlikely event that a patient misses or cancels three or more consecutive appointments/classes, this could result in dismissal from our practice. Please contact the office and we will supply you with information on obtaining your medical records and refer you to another care provider.

Cancelling appointments

Email confirmations are considered a courtesy. If you need to cancel/reschedule your appointment you may do so more than 24 hours of your scheduled appointment time by calling our office at 603-434-3456.

Cancellations via email will not be considered cancellations and will be subject to a \$20 fee for the missed appointment.

Payment

Insurance information, if applicable, must be received prior to your scheduled appointment. **It is the patient's responsibility to verify insurance coverage at this office prior to the start of care.**

Payment is required at the time of service for appointments. Co-pays and referrals (if required by your insurance) must be received at each visit, or you may be asked to reschedule your appointment. Co-pays are due at the time of service, as per your insurance guidelines.

Discount Plans

Plans for multiple visits for chiropractic care may be purchased at a discounted rate. Payment for all health investment plans is non-refundable with few exceptions. If your situation does warrant a refund, any and all used appointments/classes on the discount plan are rated at the per diem price.

Please note that all discount plans have expiration dates. It is the patient's/student's responsibility to note when the expiration date is for their particular discount plan.

Signature _____

Date _____



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Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice.

A partial list of your rights includes, but is not limited to allowing (or prohibiting) health care providers from revealing information with your permission, as necessary, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing services rendered.

Information includes, but is not limited to medical records, diagnostic reports, treatments, test and results, billing, and referrals, as well as personal data such as birth date, etc.

We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. We will gladly explain all aspects of your care to you or assigned persons as you wish.

Privacy Policies of Healing Hands Chiropractic, LLC

The Health Insurance Portability and Accountability Act (HIPAA) is in effect. HIPAA has certain requirements with which health care providers are required to comply.

We are required to give each patient notice of Privacy Practices (above) listing in which we might use your Protected Health Information. Please sign below, hereby stating that you have received the notice, and return the lower portion to us. Thank you for helping us comply with these regulations.

I give Healing Hands Chiropractic permission to treat me in a semi-private room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations upon my request.

Patient Name (printed) _____

Patient Signature _____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner(s) named above other health care professionals to whom I am referred and to the insurance carrier or any other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.

Patient Signature _____ Date _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Signature _____ Date _____ Relationship _____

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Terms of Acceptance

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals.

It is not the goal of this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because our absolute conviction that every human being functions better on all levels when no subluxations are present.

I _____ undertake chiropractic care at Healing Hands Chiropractic on the understanding of and agreement with the above explanation.

Signature _____ Date _____