

Whom may we thank for referring you to this office → \_\_\_\_\_?

# APPLICATION FOR CARE AT Hanson Chiropractic Center Dr. Ryan Hanson, D.C.

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Carrier: AT&T Sprint Verizon T-Mobile Other: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_

Secondarily: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate you're above complaints by **circling the number**:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant OR  I experience it on and off during the day OR  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes If yes, when: \_\_\_\_\_ by whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ what were the results? \_\_\_\_\_

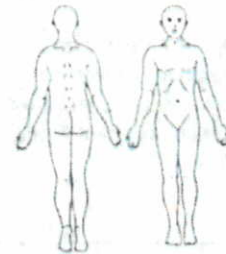
Name of Previous Chiropractor: \_\_\_\_\_  N/A

\*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

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

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____	_____
_____	_____
_____	_____

Is your problem the result of ANY type of accident?  Yes,  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_

\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes If yes how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes If yes, please state what type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ how long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable → please explain.

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for currently have and N for Never have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability  
\_\_\_ Cancer \_\_\_ Heart Attack \_\_\_ Osteoarthritis \_\_\_ Diabetes \_\_\_ Cerebral vascular \_\_\_ other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

**SOCIAL HISTORY**

- 1. Smoking:  cigars  pipe  cigarettes how often?  Daily  Weekends  Occasionally  Never
- 2. Alcoholic Beverage: consumption occurs  Daily  Weekends  Occasionally  Never
- 3. Recreational Drug use:  Daily  Weekends  Occasionally  Never
- 4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg.2  
Activities of Daily Life

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to Hanson Chiropractic Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date Form Reviewed

Patient's Name: \_\_\_\_\_

HR#: \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

JDD, DC 5/2011

## INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? \_\_\_\_\_

What speed was the collision? \_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_

When was your most recent strain / stress at work? \_\_\_\_\_

Please describe the manner of the injury \_\_\_\_\_

Was treatment received? Please describe \_\_\_\_\_

Does your job require you remain in long term stressful postures? \_\_\_\_\_

(I.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? \_\_\_\_\_

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field \_\_\_\_\_

Trauma as a child! I.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident \_\_\_\_\_

Work around the house – lifting, bending, woke up with stiff neck, “back went out”

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## INITIAL NERVE SYSTEM PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? \_\_\_\_\_

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

How many days per week do you skip on meal? (0) (1) (2) (3) (4+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4-5)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink 1 (or more per day) of any of the following? (Circle all that apply)

Diet Soda      Coffee      Juice      Milk      Soda      Alcohol

Please list any supplements you take regularly.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Activities of Daily Life

Patient Name: \_\_\_\_\_

File# \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Concentrating	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Computer Work	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Gardening	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Playing Sports	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Recreation Act.	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Shoveling	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Sleeping	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Watching TV	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Carrying	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Dancing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Dressing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Lifting	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Pushing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Rolling Over	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Sitting	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Standing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Working	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Climbing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Doing Chores	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Driving	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Sexual Activities	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Reading	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Running	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Sitting to Standing	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform
Walking	<input type="checkbox"/>	No Effect	<input type="checkbox"/>	Painful (Can Do)	<input type="checkbox"/>	Painful (Limits)	<input type="checkbox"/>	Unable to Perform

**Please mark P for in the Past, C for Currently have and N for Never**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Colon Trouble            | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Diarrhea/Constipation    | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Menstrual Problem        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Learning Disability      | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Trouble Sleeping         | <input type="checkbox"/> Hepatitis (A,B,C)    |

**List Prescription & Non-Prescription drugs you take:**

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# OUR OFFICE POLICIES

## ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

### Dr. Ryan Hanson, a Maximized Living Chiropractor

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return.

**YOUR CARE** - When a patient seeks chiropractic health 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 at Hanson Chiropractic Center is rendered primarily to minimize and reduce subluxations. The doctor uses Petabon Spinal Correction and activator adjustments through a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

**FIRST DAY GOALS**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining 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 subluxations while teaching patients what they need to do to maintain their health for a lifetime, in addition to being adjusted.

**PATIENT'S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

**PATIENT PRIVACY** -It is important to understand that any conversations you have with the doctor could potentially be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

**INSURANCE COVERAGE**- All services that are billable to insurance will be submitted, as outlined according to the care plan recommended by the doctor. Not all chiropractic services are billable/covered by insurance companies. Any insurance coverage will be verified within 48 hours of the patient's first appointment. Payments for all charges are due in full until the verification is complete. All verifications are an estimate of coverage based on the information provided by the policy and not a guarantee of payment. Any balance remaining after payment is the responsibility of the patient.

**PAYMENTS**- Based on the care prescribed by the doctor, payment options will be presented on your 3<sup>rd</sup> visit during the Patient's Report of Findings. We accept Cash, Check, VISA, Mastercard, AMEX or Discover. Additionally, please let us know if you have a Health Savings Account or Health Reimbursement Account. Some payment arrangements do require that we maintain a valid credit card on file through our secure online processing service. Non-refundable items include: Supplements, Headweights, Traction, Wobble Cushion, and opened packages of Spinal Moldings or

# OUR OFFICE POLICIES

Wedges. If you choose to discontinue care at any time, payment/refund for services rendered will be collected upon close of account. Account will not be closed until all outstanding insurance claims are processed by the patient's insurance company. If patient balance remains unpaid after two notices of payment due are sent, a fee of \$10 will be charged for certified mail and collection services acquired to seek payment. Hanson Chiropractic Center utilizes Action Collections to acquire unpaid balances after 3 months of non-payment.

Over time it is our goal that you gain a greater understanding as to the purpose of chiropractic. Patients who are accepted for care have a unique opportunity to observe firsthand the positive results and benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you. Together, we can make affirmative changes in your life and the lives of those you care about.

If you have any questions regarding these policies, before submitting your *Application for Care*, please ask and we will be happy to discuss them with you further. We want you to make an informed decision about your applying for care at this office. Therefore, it is important for you to understand these policies, how Dr. Ryan practices chiropractic, and how we can help you receive the best care to achieve your goals for health.

*Note: Patient and Office retains a copy of this policy agreement.*

*I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document. I assign to Hanson Chiropractic Center the rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by this provider. By paying my provider directly, my insurance company or employer is fulfilling its obligation to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.*

*My signature acknowledges that I have received a copy of these policies and understand this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
HR#

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## **Hanson Chiropractic Center's NOTICE OF PRIVACY PRACTICE**

This office 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. Keep this page for your records.

### **PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. 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.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
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, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
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.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### **COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Dr Ryan at (405) 341-0494. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 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:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201



# Hanson Chiropractic Center

1717 S. Boulevard Suite B, Edmond, OK 73013

## TERMS OF ACCEPTANCE

*When a patient seeks chiropractic health care & we accept a patient for such care, it is essential for both to be working towards the same objective.*

**Chiropractic has one primary goal.** It is important that each patient understand both the objective & the method that will be used to attain it. This will prevent any confusion or disappointment:

- **Problem: Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function & interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
- **Solution: Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments on the spine.
- **Goal: Health:** A state of optimal physical, mental & social well-being, not merely the absence of disease or infirmity.

**We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.**

However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

**OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read & fully understand the above statements.  
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.  
I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

## Office Appointment Cancellation Policy

At Hanson Chiropractic, we understand that unexpected circumstances may arise. However, in order to provide the best service to all of our patients, we ask that you please follow our appointment cancellation policy:

### 1. Cancellation and No-Show Policy:

- If you need to cancel or reschedule your appointment, we require a minimum of **24 hours' notice**.
- **Cancellations or no-shows with less than 24 hours' notice** may result in a **cancellation/no-show fee**.

### 2. Late Arrivals:

- Arriving late may result in a longer wait time. If you arrive **more than 15 minutes late**, we may need to reschedule your appointment.

### 3. Emergency Cancellations:

- We understand that emergencies happen. If you need to cancel your appointment due to an emergency, please contact us as soon as possible.

### 4. Fee Structure:

- **Cancellation Fee/No-Show Fee: \$30**

### 5. How to Cancel:

- You can cancel or reschedule your appointment by calling our office at 405-341-0494 or emailing us at [hansonccedmond@gmail.com](mailto:hansonccedmond@gmail.com).

We appreciate your understanding and cooperation in helping us maintain a smooth and efficient scheduling system for everyone.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_