Greetings!

Welcome to Gaslight Family Chiropractic and thank you for trusting us with your health and wellness needs. Currently, our office is exclusively in network with Blue Cross Blue Shield (BCBS). We are happy to offer a cash rate to those that do not have BCBS, and the rates are as follows:

New Chiropractic Patient Exam/Adjustment $150

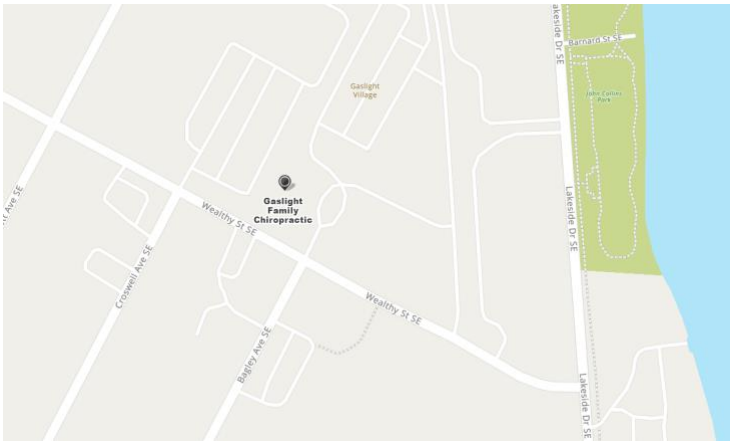
Follow Up Adjustments $70

Additionally, GFC has a team of incredible licensed massage therapists, and as a new patient to our office we are pleased to offer $15 off your first massage with us. Please let one of our patient care team members know if you would like to schedule a massage along with your chiropractic exam.

Note: If you park in the parking ramp, please bring your ticket in with you to your appointment. We can validate your ticket, which makes parking free of charge to you!

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, we ask that you show 20 minutes early so you can complete it prior to your appointment. If you have BCBS for insurance, we also ask that you bring a form of picture ID and your insurance card to your appointment as well.

If you need to change this appointment, we ask that you give at least 24-hour notice. Failure to provide at least 24-hour notification will result in your deposit being withheld. Please call our office directly at 616.458.2348 or email us at info@gaslightchiro.com.



Gaslight
FAMILY CHIROPRACTIC

OUR PRACTICE ETIQUETTE

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

- If you're feeling unwell or have any symptoms such as coughing, sneezing, fever, chills; etc. Please notify the office and we will request that you return when you are feeling better.
- Please allow ample time if you should need to reschedule your appointments. We require at least 24 hours notice to avoid late cancel/no show fee of $45 per missed appointment. You may email, call, or text. Feel free to text directly to our office manager, Carmel, at 512.712.6232. Do not reply to auto-text reminders.
- GFC Pro Tip: We validate parking from the ramp behind our building. Please bring your ticket to the front desk and we will validate it. Yay- free parking!
- Please silence cellphones upon arrival. If you should need to take a call, step out of the office as a courtesy to other patrons.
- 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 session has completed. Please be mindful of this after your massage.
- If you are satisfied with your massage therapy experience, there are 3 ways to leave gratuity if you should desire: Cash, Credit Card (3% processing fee incurred), and Venmo. Typical industry standard for gratuity is 15-20% of the face value of your service rendered. Gratuity is never expected, but always appreciated.
- Later appointment slots are those most coveted. If you have day, time, and/or doctor & 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...
    - MedStones: no added time -add to any massage
    - Myofascial Cupping: no added time - Select LMTs
    - Hair/Saliva Testing, Functional Medicine
    - Whole food supplements- Standard Process
    - Pillowise custom fitted pillows
    - Craniosacral Therapy
    - Acupuncture
- Ask us about our rewards program- Wellness Bucks

THANK YOU FOR TRUSTING US WITH YOUR HEALTH

Gaslight
FAMILY CHIROPRACTIC

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 Gaslight Family Chiropractic (GFC) to include all care for my condition.

- I consent to treatment, diagnostic, or therapeutic procedures and care by GFC. I am aware that the practice of chiropractic, 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, there are certain complications that 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 GFC has no responsibility for 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.

FINANCIAL RECORDS AUTHORIZATION AND INSURANCE ASSIGNMENT OF BENEFITS
I agree to pay GFC for these 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 GFC in collecting this account. I also agree to assign to GFC 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 GFC to release any billing information for payment of account by any insurance company or employer. I authorize any insurance companies to pay directly to GFC liability and/or medical insurance proceeds for all services and supplies rendered by GFC for treatment. I understand that I am financially responsible to GFC for all services and supplies not covered by the liability and/or medical coverage insurance.

_____ I understand that GFC is exclusively in-network with **Blue Cross Blue Shield** and services I receive can be billed directly to BCBS through GFC. 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 it is my responsibility to notify GFC 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

_____ If my benefits exhaust or I fail to notify GFC that I am receiving chiropractic services at another facility, I accept responsibility of any unpaid balances.

MEDICAL RECORDS AUTHORIZATION AND DISCLOSURE
I authorize GFC to release the minimum necessary information contained in my patient record (including photographs, videotapes, audio recordings or other digital images) to other health care 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, Gaslight Family Chiropractic 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, 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 GFC may share my health information for treatment, payment, and healthcare operations.

CANCELATION AND NO-SHOW
As a courtesy to our patients, we send text/email appointment reminders the day before their appointment. The text/email reminders are not guaranteed, and the fee is not waived if an appointment reminder is not made. I understand that if I am unable to keep my scheduled appointment it is my responsibility to give GFC at least 24-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.**

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

PATIENT REPRESENTATIVE
I authorize Gaslight Family Chiropractic staff permission to verbally share my medical information on voicemail or in person with the following person (s):

Name	Relationship	Phone

Patient Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Gaslight FAMILY CHIROPRACTIC

PATIENT REGISTRATION QUESTIONNAIRE

DEMOGRAPHICS

Name: _____ DOB: _____
Cell Number: _____ Home 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 your own subscriber, write self)

Name: _____ DOB: _____
Gender: ☐ Male ☐ Female Relationship to Patient: _____

Is your appointment related to an auto accident?

☐ Yes ☐ No
If yes, Insurance Company: _____
Claim Number: _____
Adjustor Name: _____ Adjustor Phone Number: _____
Date of Accident: _____ SSN: _____

HOW DID YOU HEAR ABOUT US?

☐ Social Media ☐ BCBS Website ☐ Google/Yelp ☐ Friend/Family
☐ Other ☐ Current GFC 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: _____

Gaslight FAMILY CHIROPRACTIC

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Date: _____

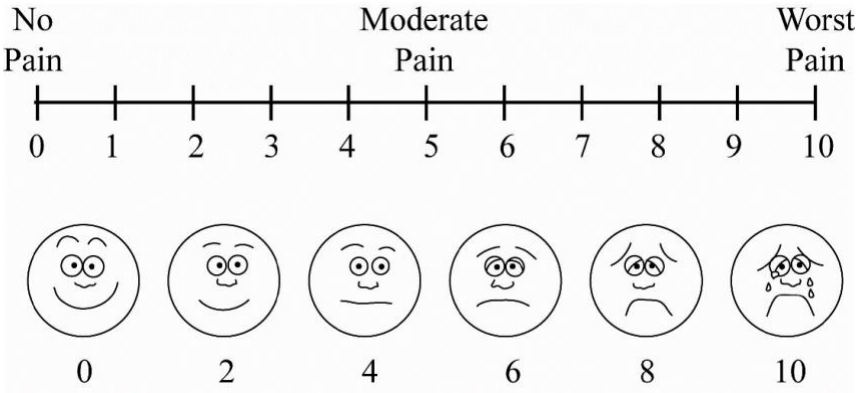
Directions: Please circle ONE answer per question that indicates your ability to perform the following activities. If the activity does not pertain to you, please place an "X" in the "N/A" column.

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.

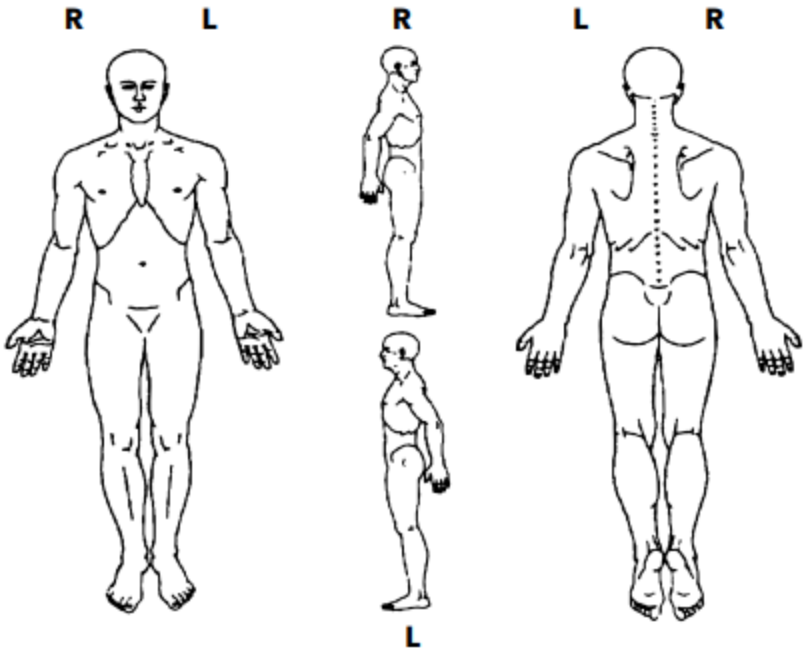
Using the pain scale below, circle the number that best describes the pain you have experienced at your worst.



Gaslight FAMILY CHIROPRACTIC

HEALTH HISTORY QUESTIONNAIRE

CURRENT COMPLAINT(S)
Please place an "X" in all locations where you are experiencing pain, discomfort, or other symptoms:



Primary complaint: _____

Please describe the condition: _____

When did your symptoms first appear? _____

Most recent occurrence date: _____

What do you think caused the problem? _____

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain…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)

(please circle) …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 ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

Does the pain travel from one location to another? ☐ Yes ☐ No

If yes, from where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes & goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐N /A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Sitting
☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ N/A
☐ Other _____

Pain worsens with: _____Pain improves with: _____

Notes:_____
_____

Please list treatments received (previous therapy, medication, acupuncture, chiropractic) and if they helped you.

_____
_____

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

_____
_____

Have you ever seen a chiropractor for this complaint before? ☐ Yes ☐ No

Additional complaint: _____
Please describe the condition: _____
When did your symptoms first appear? _____
Most recent occurrence date: _____
What do you think caused the problem? _____
Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain…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)
(please circle) …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 ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____
Does the pain travel from one location to another? ☐ Yes ☐ No
If yes, from where to where? _____
How often do you have this pain? ☐ Constantly ☐ Comes & goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly
Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐N /A
Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Sitting
☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ N/A
☐ Other _____
Pain worsens with: _____Pain improves with: _____

Notes:_____
_____

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

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

☐ Other: _____

Please list any medications/supplements you are currently taking, or bring a list we can copy:_____
_____

Please list any surgeries or recent hospitalizations:
_____
_____
_____

Additional Notes:
_____
_____
_____

PHYSICAL & TRAUMA INFORMATION
Work Activities ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other _____

Work Injuries ☐ Yes ☐ No If yes: _____
Sport Activities: _____
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 & LIFE 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

FAMILY HISTORY

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

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