ADVANCED SPINAL CARE

CHIROPRACTIC REHABILITATION - WEIGHT LOSS - NATURAL MEDICINE

Date: _____

Name:_____ Address:_____
City:_____State:_____Zip/PostalCode:_____
Home Phone: _____ Cell Phone: _____
Birth Date: _____ Age: _____Sex: Male or Female
Height: _____ Weight: _____ Social Security #:_____(Medicare only)
E-Mail Address:_____ May we email you patient education material? Yes No
Business Employer:_____ Business Phone:_____

Who referred you to this office or how did you hear about us? _____

Name of Emergency Contact: _____Phone Number: _____
Relationship: _____

Who is Responsible for Your Bill? You and ❑ Workers' Comp. ❑ Auto Insurance ❑ Health Insurance ❑ Self Pay

Primary Care Physician (PCP):_____ Location:_____
May we send your PCP updates on your treatment from our office? ❑ YES ❑ NO Initial_____

Accident Information
Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Health History

What are we seeing you for today? _____

Please list current medical treatments including medications:_____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

Is there a FAMILY HISTORY of any of the following conditions?

❑ Heart Disease ❑ Diabetes ❑ AutoImmune Conditions ❑ Cancer ❑ Arthritis ❑ Other_____

How often do you exercise? _____

Are you interested in learning about our weight loss and wellness program? ❑ YES ❑ NO

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

Doctor Initial: _____ Date: _____

PERSONAL HEALTH HISTORY

Patient's Name _____DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Please check the all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

Constitutional: ❑ Deny All
❑ Fatigue
❑ Fever
❑ Night Sweats
❑ Rapid Weight Gain
❑ Rapid Weight Loss

Eyes/Vision: ❑ Deny All
❑ Cataracts
❑ Change in Vision
❑ Visual Field Defect
❑ Glaucoma
❑ itching (around eyes)
❑ Light Sensitivity
❑ Wears corrective lenses

Ears, Nose, Throat: ❑ Deny All
❑ Difficulty Swallowing
❑ Frequent Dizziness
❑ Ear Pain
❑ Fainting
❑ Loss of Smell
❑ Recurrent Sinus Infections
❑ Snoring
❑ Tinnitus (ringing in ears)
❑ TMJ Problems
❑ Ear Infections

Respiratory: ❑ Deny All
❑ Asthma
❑ Cough
❑ Shortness of breath
❑ Wheezing
❑ Emphysema

Allergy ❑ Deny All
❑ Anaphylaxis (history of)
❑ Food intolerance
❑ Seasonal

Hematology ❑ Deny All
❑ Anemia
❑ Blood Clotting Problem
❑ Bruise Easy
❑ Lymph Node Swelling

Cardiovascular ❑ Deny All
❑ Chest Pain
❑ Heart Murmur
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Palpitations
❑ Swelling of Legs

Gastrointestinal ❑ Deny All
❑ Abdominal Pain
❑ Frequent Belching
❑ Black, Tarry Stool
❑ Constipation
❑ Diarrhea
❑ Difficulty Swallowing
❑ Heartburn
❑ IBS
❑ Frequent gassy/bloating
❑ Rectal Bleeding
❑ Changes in stool consistency
❑ Vomiting
❑ Vomiting Blood

Women only ❑ Deny All
❑ Birth Control Therapy
❑ Breast Lumps/Pain
❑ Frequent Urination
❑ Hormone Therapy
❑ Irregular Menstruation
Are You Pregnant? Yes / No
Date of Last Period_____

Men only ❑ Deny All
❑ Burning Urination
❑ Erectile Dysfunction
❑ Frequent Urination
❑ Hesitancy/Dribbling
❑ Prostate Problems
❑ Urine Retention

Endocrine ❑ Deny All
❑ Cold Intolerance
❑ Heat Intolerance
❑ Diabetes
❑ Excessive Hunger
❑ Excessive Thirst
❑ Frequent Urination
❑ Thyroid Problems
❑ Hair Loss
❑ Unusual Hair Growth

Skin ❑ Deny All
❑ Changes in Nail Texture
❑ Changes in Skin Color
❑ Hair Growth
❑ Rash
❑ Eczema
❑ Paresthesias (tingling in skin)

Nervous System ❑ Deny All
❑ Frequent Dizziness
❑ Facial Weakness
❑ Headaches
❑ Limb Weakness
❑ Loss of Consciousness
❑ Loss of Memory
❑ Numbness
❑ Seizures
❑ Sleep Disturbances
❑ Slurred Speech
❑ Stress
❑ Strokes
❑ Tremors
❑ Unsteadiness of Gait

Physiologic ❑ Deny All
❑ Anxiety
❑ Depression
❑ Behavioral Changes
❑ Bipolar Disorder
❑ Confusion
❑ Convulsions
❑ Mood Changes

Others:
❑ Alcoholism
❑ Anemia
❑ Arteriosclerosis
❑ Cancer
❑ Osteoporosis
❑ Diabetes
❑ Epilepsy
❑ Gout
❑ HIV / Aids
❑ Pacemaker
❑ Use tobacco
❑ Stroke
❑ Tuberculosis
❑ Ulcers

Doctor Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and received the Notice of Privacy Practices of Advanced Spinal Care.

_____
Signature of Patient/Guardian Date

_____ (Initial) I acknowledge that it is the policy of Advanced Spinal Care to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ (Initial) I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Brent Wall, D.C., about my concerns.

_____ (Initial) I acknowledge that some of my treatment will be done in a common treatment area. If you need to share private information or need to be treated in a private room, a private room is always available upon request.

_____ _____
Witness (Office Staff) Date

AUTHORIZATIONS

I authorize Advanced Spinal Care to disclose or discuss the following information:

- Appointments Yes / No
- Accounts/Balances Yes / No
- Insurance Yes / No
- Treatment Yes / No

If **YES**, please list the persons authorized to receive your Protected Healthcare information:

Full Name: _____ Relationship_____

Full Name: _____ Relationship_____

PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS

POLICY- a way of managing affairs so as to achieve some purpose.

APPOINTMENT- a meeting with someone at a certain time and place.

MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all 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 your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. There is a $25.00 service charge if you don't give us 24 hours of notice or if you don't show up to your massage appointments, we still have to pay the Therapist.
7. There is a $25.00 charge for No call/No show appointment with the Chiropractor.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____

Staff Witness: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.
We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.
It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.
I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature:_____Date:_____
Witness Name: _____ Signature:_____Date:_____

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDERS: Brent Wall, D.C., Steven Davis D.C.

PATIENT Name:_____
Date:_____

In consideration of your undertaking to render care, I agree to the following:

1. Release of information: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. Right to receive information: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.

3. Right to receive payment: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

4. Assignment of right to sue: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

5. I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.

6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.

7. I hereby acknowledge that I am receiving (or about to receive) health care services from Advanced Spinal Care and am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.

Date: _____ Patient Signature: _____

Date: _____ Witness: _____