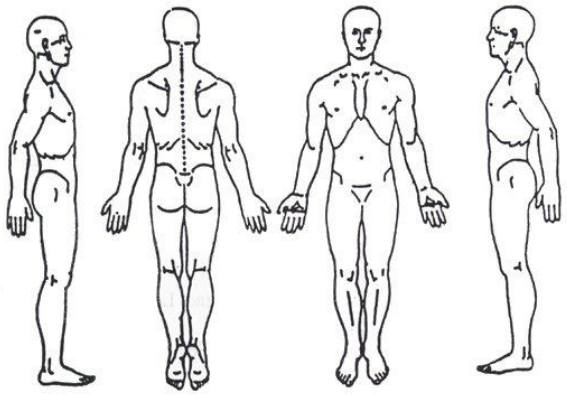
New Patient Registration and History

Patient's Name: _____ Today's Date: _____

1. Patient Condition



Reason for Visit:_____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling:
Rate the severity of your pain on a scale from 1 (lease pain) to 10 (severe pain): ___
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

2. Health History

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____
Name and address of other doctor(s) who have treated you for your condition: _____
Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-scan, Bone Scan_____
Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	MS	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lumps	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herniated Disc	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chem. Depend.	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other: _____		

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please list all injuries/surgeries you have had: Description Date
Falls_____ _____
Head Injuries_____ _____
Broken Bones_____ _____
Dislocations_____ _____
Surgeries_____ _____

3. Lifestyle

Exercise	Work Activity	Habits	Values
☐ None	☐ Sitting	☐ Smoking	Please list you interests in order of importance from 1-8.
☐ Moderate	☐ Standing	☐ Alcohol	(1= most important)
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	____Family ____Financial ____Social ____Physical
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	____Mental ____Spiritual ____Work ____Nutrition

4. Medications

1. _____
2. _____
3. _____

Pharmacy Name: _____

Pharmacy Phone: (____)_____

Allergies

1. _____
2. _____
3. _____
4. _____

How often do they occur?

_____

Vitamins/Supplements

1. _____
2. _____
3. _____
4. _____

☐ Daily ☐ Weekly ☐ Monthly

5. Patient Information

Date:_____

Patient Name (Last)_____

(First)_____ (MI)_____

Email_____

Address_____

City_____

State_____ Zip_____

Sex: ☐ Female ☐ Male Age_____

Birth Date_____

Social Security/DL_____

☐ Married ☐ Single ☐ Partnered for _____ Years

Patient Employer/School_____

Occupation_____

Employer/School Address_____

Employer/School Phone_____

Spouse's Name_____

Birth Date_____

Social Security/DL#_____

Spouse's Employer_____

Who may we thank for referring you/event you attended?

6. Insurance Information

Subscriber's Name _____

Subscribers Birth Date _____ SS# _____

Relationship to patient_____

Insurance Company_____

Patient ID#_____ Group #_____

This policy associated with a(n) ☐ HSA ☐ FSA ☐ HRA ☐ None

Is this patient covered by additional/secondary insurance? ☐ Yes ☐ No

If yes, please fill out the information in the box below.

Secondary Insurance Information

Subscriber's Name_____

Birth Date_____ SS#_____

Relationship to patient_____

Insurance Company_____

Patient ID#_____ Group#_____

Assignment and Release

By signing below, I certify that the information on this form is accurate and up-to-date. I certify that I, and/or my dependent(s) have insurance coverage with the aforementioned company(ies) and assign directly to AWC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that 1) I am financially responsible for all charges whether or not paid by insurance and 2) I am financially responsible for any legal fees incurred by AWC for collection efforts of delinquent balances on my and/or my dependent's(s') account(s).

I authorize the use of my signature on all insurance submissions. The above-named office may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date below.

_____

(Signature of Patient, Parent, Guardian or Personal Representative)

_____

(Please print name of Signature of Patient, Parent, Guardian or Personal Representative)

_____

(Date) (Relationship to patient)

7. Phone Numbers

Cell Phone ( ) _____-_____ Home ( ) _____-_____

Best time and place to reach you _____

In Case of Emergency, Contact

Name_____ Relationship _____

Home Phone ( ) _____-_____ Work ( ) _____-_____

8. Family Information

Children's Name(s)	Sex	Dates(s) of Birth
_____	M F	_____
_____	M F	_____
_____	M F	_____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic only has one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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 of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Chiropractic care like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care from Advanced Wellness Center, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, you spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to beginning care.

It is important to note, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. 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 services of another health care provider. 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. However, we may use other procedures to help your body hold the adjustments.

I understand and accept that there are risks associated with chiropractic care and give me consent to the examinations that the chiropractor deems necessary, and to the chiropractic care including spinal adjustments, as reported following assessment.

_____

(Signature) (Date)

Consent to evaluate and adjust a minor child

I,_____ being the parent of legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above practice and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of late menstrual period: _____ /_____ /_____

_____

(Signature) (Date)

Agreements and Authorization

Consent to Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf) hereby request and consent to Patient health care services from Advanced Wellness Center. The Patient health care services will be provided by licensed, treating chiropractors. Health care services will also be provided by non-chiropractic health care professionals employed, under contract, or otherwise retained by Advanced Wellness Center. Medical, nursing, and other health care professionals who are in training may also participate in the Patient's care as part of their education.

_____initial

Payment Guarantee

In consideration of the services provided by Advanced Wellness Center, Provider to Patient, you agree to; I) Guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Advanced Wellness Center, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Advanced Wellness Center. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits and the payment of any legal fees incurred by Advanced Wellness Center for efforts to collect any delinquent balances of aforementioned unpaid Patient Charges.

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. If your insurance policy does not cover services rendered from this office, then you are responsible for the non-covered services at the time they were rendered. If you have a Health Savings Account (HSA), Flex Spending Account (FSA) or a Health Reimbursement Arrangement(HRA), you must notify the practice so we may make appropriate accommodations for the plans. Advanced Wellness Center does not directly bill to any HSA, FSA, or HRA plans; however, depending on your plan arrangements, automatic withdrawals may occur when we submit to your primary insurance. Any refunds or reimbursements to HSA, FSA or HRA plans cannot exceed your "out of pocket" contribution towards any treatment. (Excludes introductory screening offer if applicable, all services will be discussed prior to being provided)

_____initial

Medicare

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII (18) of the Social Security Act is correct. You authorize any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. You authorize payment or authorize benefits to Advanced Wellness Center on Patients behalf.

_____initial

Consent to Release of Information

Please Continue and Sign Consent to Release of Information

Here at Advanced Wellness Center we respect your privacy, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Advanced Wellness Center to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal governments etc.), insurance companies, or other third-party payers and their agents, and its collection representative and attorneys, the following "Patient Information": medical history, diagnoses, and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for the Patient's health care services or billing and collection of amounts due to Advanced Wellness Center for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professionals, including treating physician(s), to provide Advanced Wellness Center or its designee with Patient Information for quality assurance and/or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Advanced Wellness Center is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again here at Advanced Wellness Center we strive to provide you with the best care possible and in order to do that this consent is needed.

_____Initial

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Advanced Wellness Center for safekeeping under its sole care and custody.

No revisions or changes to this form by you will be accepted by Advanced Wellness Center

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(Signature of Patient or Responsible Party: parent, guardian, or other representative) (date)

(Signature of Policyholder) (relationship) (date)

(Signature of Witness to signing of consent form) (date)

Patient Privacy Acknowledgement

For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations

I,_____ hereby state that by signing this Consent I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encourage me to read the Privacy Notice carefully prior to my signing this Consent.
2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3) This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfactions in a way that I can understand.

(Name of Individual, Printed)	(Date)	(Signature of Individual)
(Signature of Legal Representative)	(Date)	(Relationship)
(Witness—Office Personnel)	(Date)	