6769 Courtland Drive, Ste. 100
Rockford, MI 49341
616-863-9482

Confidential Patient Health Record Date: _____ I.D. # _____

DEMOGRAPHIC INFORMATION

Name_____ City: _____

Address: _____ State: _____ Zip: _____

Email address:_____ Cell Phone: _____

Home Phone: _____ Birth Date: _____ Age: ____ Sex: ☐ M ☐ F

Social Security # _____ Circle One: Married Single Divorced Widow

Business Employer:_____ Business Address: _____

Business Phone # _____ Type Of Work: _____

Whom may we thank for referring you to us: _____

Name / Relationship of Emergency Contact: _____ Phone Number: _____

CURRENT HEALTH CONDITION

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

Are you in pain? ☐ Yes ☐ No Rate your pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Describe your pain: _____and/or circle: Dull Sharp Achy Throbbing Shooting

Did your discomfort occur during: ☐ Work ☐ Sports/Play ☐ Auto Accident ☐ Routine Household Activity

When did this condition/accident occur? ____ / ____ / ____ Where did your injury occur?_____

Please explain what happened: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes And Goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine? If so, how?

_____

What seems to help alleviate your pain?: (i.e. ice, heat, aspirin)_____

What seems to make your pain worse? _____

Does it radiate/travel into other parts of your body? ☐ Yes ☐ No Where:_____

_____

Has this or something similar happened in the past? ☐ Yes ☐ No

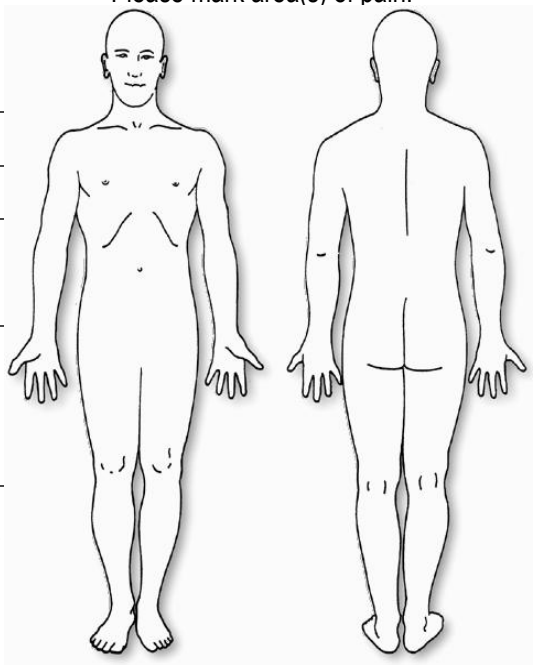
Have you seen anyone else for this condition? ☐ Yes ☐ No Who? _____

_____

Type of Treatment: _____ Results:_____

If you chose yes, please fill out the attached Records Exchange form.

Please mark area(s) of pain:



Medications you are currently taking: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

Name:_____ Dosage: _____ Prescribed for: _____

Name:_____ Dosage: _____ Prescribed for: _____

Name:_____ Dosage: _____ Prescribed for: _____

Do you suffer from any condition other than that of which you are now consulting us? _____

PAST HEALTH HISTORY

Please Check / Describe:

Major Surgery / Operations: ☐ Back Surgery ☐ Broken Bones ☐ Bone Fusions ☐ Disc Surgery

☐ Other: _____

Major Accidents / Injuries / Falls:_____

Hospitalizations (Other Than Above): _____

LIFESTYLE

Do you take any supplements? ☐ Yes ☐ No If so, which one(s): _____

Do you exercise? ☐ Yes ☐ No Activity: _____ Amount: _____ day / wk

Do you smoke? ☐ Yes ☐ No Amount: _____ day / wk

Do you drink alcohol? ☐ Yes ☐ No Amount: _____ day / wk

Do you get eight hours of sleep every night? ☐ Yes ☐ No If not, why? _____

How would you classify your stress level? None 1 2 3 4 5 6 7 8 9 10 Severe

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Are you pregnant? ☐ Yes ☐ No If so, what is your due date? _____

Do you have children? ☐ Yes ☐ No If so, what are their names and ages? _____

Date of your last physical examination: _____

Date of your last nutritional consultation: _____

Date of your last deep tissue massage: _____

Date of your last chiropractic adjustment: _____

Dr.'s Notes

_____

_____

_____

_____

_____

_____

_____

ChiroHealth HIPAA Form

Patient's Name: _____

Patient's SSN: _____ Date of Birth: _____

SPECIFIC AUTHORIZATIONS-CHECK ALL THAT APPLY

( ) I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, and any information about treatment(s). If **ChiroHealth Rockford** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

( ) I give **ChiroHealth Rockford** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

APPROVED ENTITIES FOR PERSONAL HEALTH INFORMATION

Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

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_____
Signature of Patient or Personal Representative

_____
Date

RIGHT TO REVOKE HIPAA AUTHORIZATION

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  ChiroHealth Rockford
  Attn: Office Manager
  6769 Courtland Dr. Ste. 100
  Rockford, MI 49341
  Phone: 616-863-9482
  Fax: 616-863-9486

  Initials: _____

- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.
- Upon request, a copy of this authorization will be provided to you.
- Upon request, a copy of the Health Insurance Portability and Accountability Act will be provided to you.

ChiroHealth

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OFFICE POLICY

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best in chiropractic care and massage therapy for your whole family.

Chiropractic Appointments: (late and missed)

In order to provide proper chiropractic care, a personal treatment plan will be designed specifically for you.

- If an appointment must be changed **24 hours notice is appreciated**, but not required.
- If you are going to be late please call ahead to let us know, understanding that your appointment **may** need to be rescheduled.
- No charges will be accessed for late/missed chiropractic appointments.

Massage Appointments: (late and missed)

- No shows and cancellations made without a 24 hour notice of the appointment time will result in a charge of $35 whether a 90, 60, or 30 minute massage was scheduled.
- If a patient with insurance is 15-30 minutes late for their hour massage, the insurance can be billed for a half hour appointment and the patient will be charged for a half hour massage.
- If a patient without massage coverage is late for their appointment, it will take time from their massage and the full fee will be charged.
- When a patient is 30 minutes late without notification, the therapist is free to see another massage patient for the remainder of that hour.
- A missed appointment fee cannot be billed to your insurance.
- Hot rock massage is not covered by insurance.
- We are a family oriented office; however, we recommend that you find care for your child(ren) during these longer appointments. Please do not leave your child(ren) unattended.
- **Please Note: The 90, 60, and 30 minute massage appointment time includes the patient and room prep.** Initial _____

Financial Policies/Agreements:

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network or contractual discount under the following circumstances:
    a. We are a participating provider in your health plan.
    b. You are covered by a State or Federal program with a mandated fee schedule.
    c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our staff for more information.
    d. Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required on an annual basis.

3. You are eligible for a Time of Service discount of 10% off noninsurance covered services when you pay for your services (products excluded) the same day you receive them.
4. As part of our compliance plan, as of 8/1/15 our office will be unable to extend any type of discounts other than those listed above.
5. Patient statements are mailed once a month. After 60 days without a payment or making a payment arrangement your account may:
    a. Be accessed a late fee and /or be transferred to a collections service agency.
    b. Patient may be prohibited from scheduling appointments until payment arrangements are made. Payment arrangements should be made with the Office Manager or Patient Accounts Manager.

Treatment of a Minor:

I _____ being the parent/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 doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____ Initial_____

Financially Responsible Party:

Print Name: _____

Relationship to the patient: _____

Address if different from patient/ where the statement is to be sent:

_____

Patient Signature_____**Date**_____

Parent/Guardian Signature_____**Date**_____

Office Use Only

Primary on account selected or created _____

Date entered _____ Staff Initials _____