



PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

PATIENT NAME

DATE COMPLETED

Patient Information

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Marital Status: S M D W
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? Yes No If yes, when: ____ / ____ / ____
**If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____ / ____ / ____ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes No Do they interfere with: Work Sleep Hobbies Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain: _____

Have you been treated for this? Yes No When were you last treated? ____ / ____ / ____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? Yes No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? Yes No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? Yes No Did they recommend a Home Health Care program? Yes No

If yes, what? _____ How long were you treated? _____ Last treatment: ____ / ____ / ____

How did you respond? _____

Are you aware of any poor posture habits? Yes No Is there any history of spinal problems in your family? Yes No

If yes, explain: _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

G = STABBING

N = NUMBNESS

B = BURNING

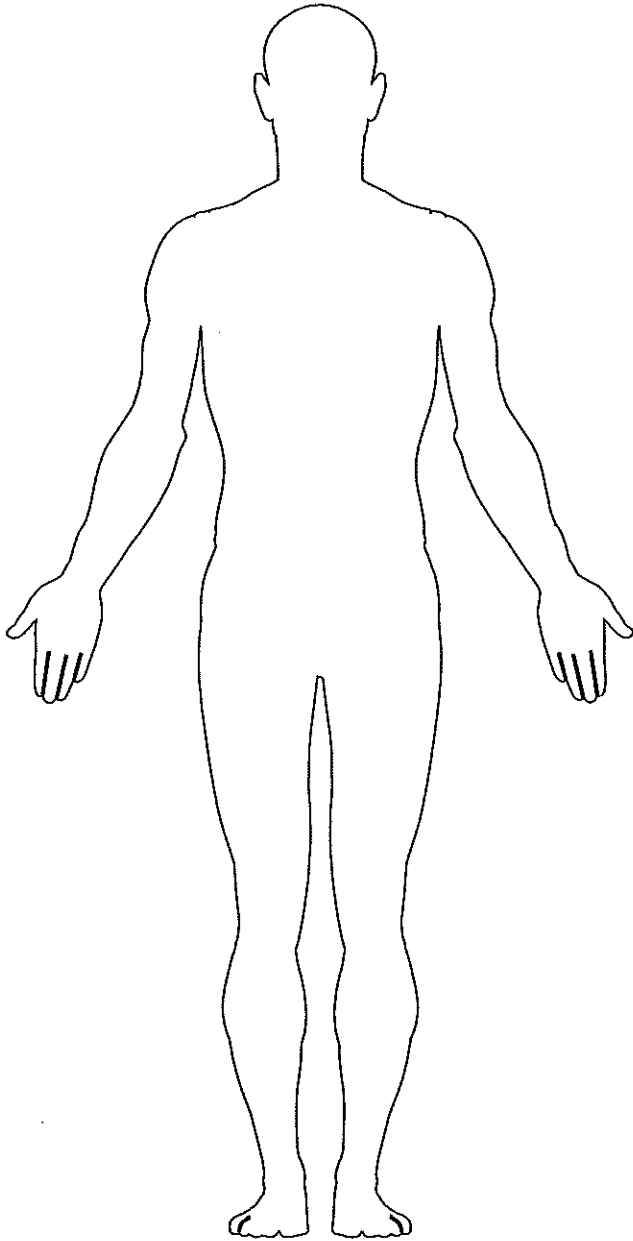
M = SPASMS

T = TINGLING

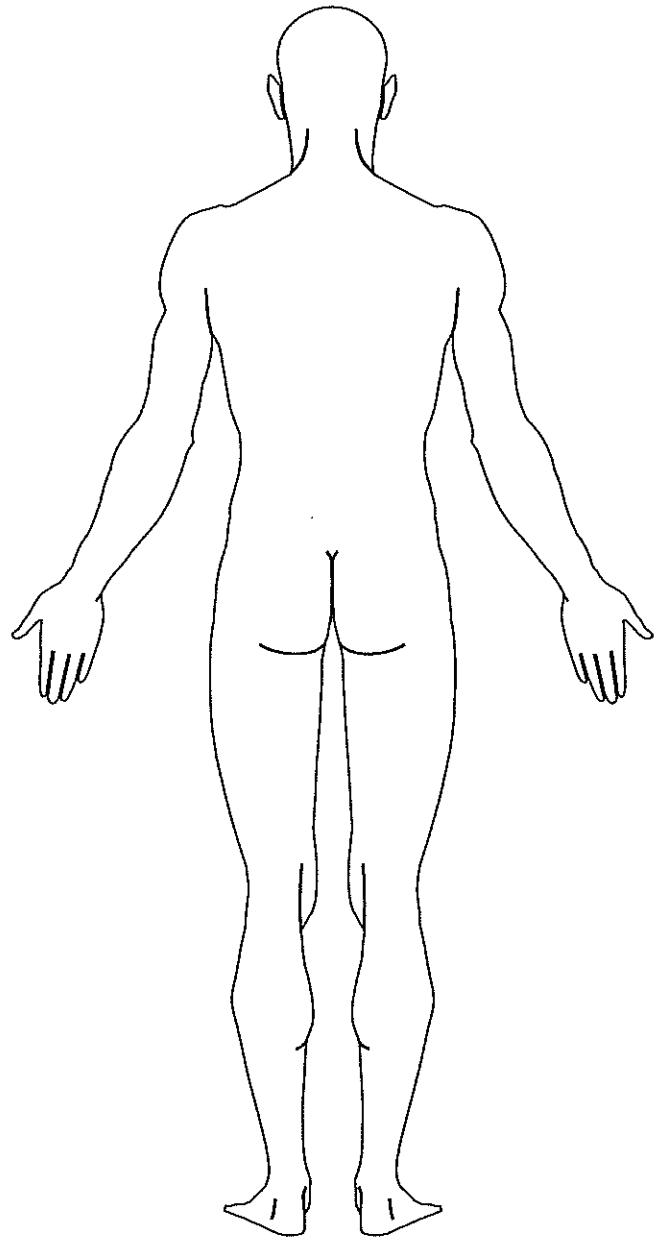
P = PINS & NEEDLES

F = STIFFNESS

O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Health & Lifestyle

Do you exercise? Yes No How often? _____ day(s) per week; Other: _____

What activities? Walking Running/Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? Yes No How much? / How often? _____

Do you drink alcohol? Yes No How much? / How often? _____

Do you drink coffee? Yes No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.¹ Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain	____ Headaches	____ Sinusitis
____ Pain in shoulders/arms/hands	____ Dizziness	____ Allergies/Hay fever
____ Numbness/tingling in arms/hands	____ Visual disturbances	____ Recurrent colds/Flu
____ Hearing disturbances	____ Coldness in hands	____ Low Energy/Fatigue
____ Weakness in grip	____ Thyroid conditions	____ TMJ/Pain/Clicking

Please explain: _____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations	____ Recurrent Lung Infections/Bronchitis
____ Heart Murmurs	____ Asthma/Wheezing
____ Tachycardia	____ Shortness Of Breath
____ Heart Attacks/Angina	____ Pain On Deep Inspiration/Expiration

Please explain: _____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|--|---|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pain in Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Hypoglycemia/Hyperglycemia |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Reflux | |
| <input type="checkbox"/> Tired/Irritable after eating or when not having eaten for a while | | |

Please explain: _____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Coldness in legs/feet |
| <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Muscle cramps in legs/feet | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |

Please explain: _____

OTHER

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

Please list any surgeries (include type of surgery and date it was performed): _____

Family Health History

Have any of your family members ever been diagnosed with the following (*please indicate "Y" for You, and "O" for Other than you, or both if applicable*):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago
<input type="checkbox"/> Other: _____			

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or staff for all services rendered.

Patient's Signature _____ Date ____/____/____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date ____/____/____

In Case of Emergency

Name _____ Relationship _____

Work Phone () _____

Home Phone () _____

Cell Phone () _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Your Clinic Name is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? Yes No

Patient's Signature _____ Date ____ / ____ / ____

Signature of Person Authorizing Care (if different from patient):

_____ Date ____ / ____ / ____

Relationship to Insured _____ Date of Birth ____ / ____ / ____

Employer _____

Primary Insurance Company _____ Policy# _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: ____ - ____ - ____

Secondary Insurance Company _____ Policy# _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: ____ - ____ - ____

MOUNTAIN WEST CHIROPRACTIC

Dr. Albert G. Simoncelli, DC, CCST
and Associates
9034 W. Sahara Ave
Las Vegas, NV 89117

POLICIES REGARDING YOUR FINANCES

Please read and initial the following statements:

_____ Payment is expected at time of, or before services are rendered. This is inclusive of Cash Plan participants. Payment must be received weekly, prior to treatment.

_____ For those patients with insurance, it is mandatory that you read and sign our insurance financial policies. Payment of deductible and co-pay is expected at time of treatment. (Payment arrangements are available for those with a sizable deductible).

_____ For those patients with Medicare and Secondary insurance, please read and sign our Medicare Guidelines Policy.

_____ If we are not able to verify insurance information, the patient will be responsible for a payment toward their account of no less than \$50.00 in addition to their estimated co-pay.

_____ Any patient with a CASH balance of \$100.00 or more will not be eligible for further treatment until the balance is paid off. (This does not include balances to be paid by insurance, only cash, co-pay, and deductible).

_____ If any account is delinquent more than 30 days, we have the right to charge a 1.75% interest rate per month, annual 21%.

_____ For your convenience, we accept cash, personal checks, Master card, Visa, Discover and American Express.

Thank you for your cooperation.

I have read and understand the above policies.

Patient Signature _____



Mountain West Chiropractic

Informed consent

Patient Name: _____

To the patient:

Please read this entire document prior to signing it.

It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

This office typically performs a very thorough examination utilizing orthopedic and neurological testing. This at times can create some soreness the doctor is looking to elicit regions of pain within your spine or extremities. This typically is temporary.

The primary treatment used within this chiropractic office is the spinal adjustment. It entails the use of adjusting segments of the spine by hand, instrument, or by using a special table with drop mechanisms. Spinal adjustments by hand may cause an audible “pop or click” similar to the sound of popping knuckles. This occurrence is a vacuum release of carbon dioxide within the joint and has been shown to have no detrimental effect to the joint itself.

The first couple of adjustments, may cause soreness around the region. This is typically due to the increased spinal range of motion which can cause muscles to become sore. This is typically temporary. If you experience this, please bring this to the attention of the doctor.

There has been some past concern of cervical spinal manipulation leading to stroke or arterial tearing. Extensive research has shown that chiropractic patients are at no greater risk than patients seeking medical treatment without manipulation, or just within the general public. At Mountain West Chiropractic, we utilize protocols to ensure your safety.

Infrequent side effects that may occur during your treatment, can be increased pain, headaches, bruising, stiffness and muscle spasm, due to the fact that we are working in the region of your pain. Other very infrequent complications can include but are not limited to: disc injuries, dislocations, cervical myelopathy, and costovertebral strains. These typically can be resolved by additional treatment(s). Always bring this to the attention of your doctor.

Some patients that are osteoporotic can experience a rib fracture. This is also infrequent, and we do our best to be gentle to those in this population group. If you have been taking corticosteroid drugs, please inform the doctor.

As a structure based office, and along with the use of therapies to decrease pain and inflammation, we utilize various treatments, such as traction, body weighting, electrical muscle stimulation, heat, ice, low level laser, and exercises utilizing exercise balls or elastic bands. All therapies are utilized at patient tolerance.

A small percentage of patients can experience jaw pain from neck traction. It is important to notify the assistant or the doctor immediately, to seek modification of the traction or an alternative for this treatment.

Ice used over the bare skin can cause superficial burning, and therefore it is not recommended.

There are risks and dangers attendant to remaining untreated; such as the formation of adhesions and reduced mobility, which may lead to a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (insert doctor's name) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian (if a minor)

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		X		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Mountain West Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ Date

_____ Signature

_____ Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ (patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- Personally Mail Phone Follow-up
- Other: _____

_____ Date

_____ Signature

_____ Print Name of Physician

Mountain West Chiropractic
Name of Practice