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

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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: ______________________________

____

____

____

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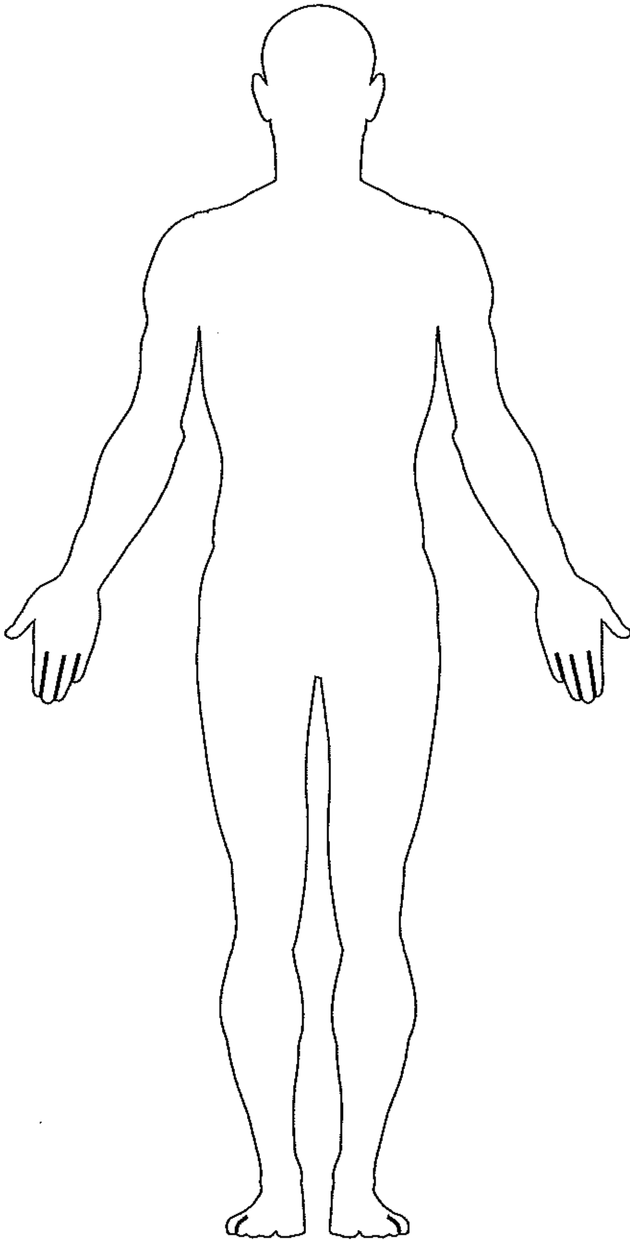
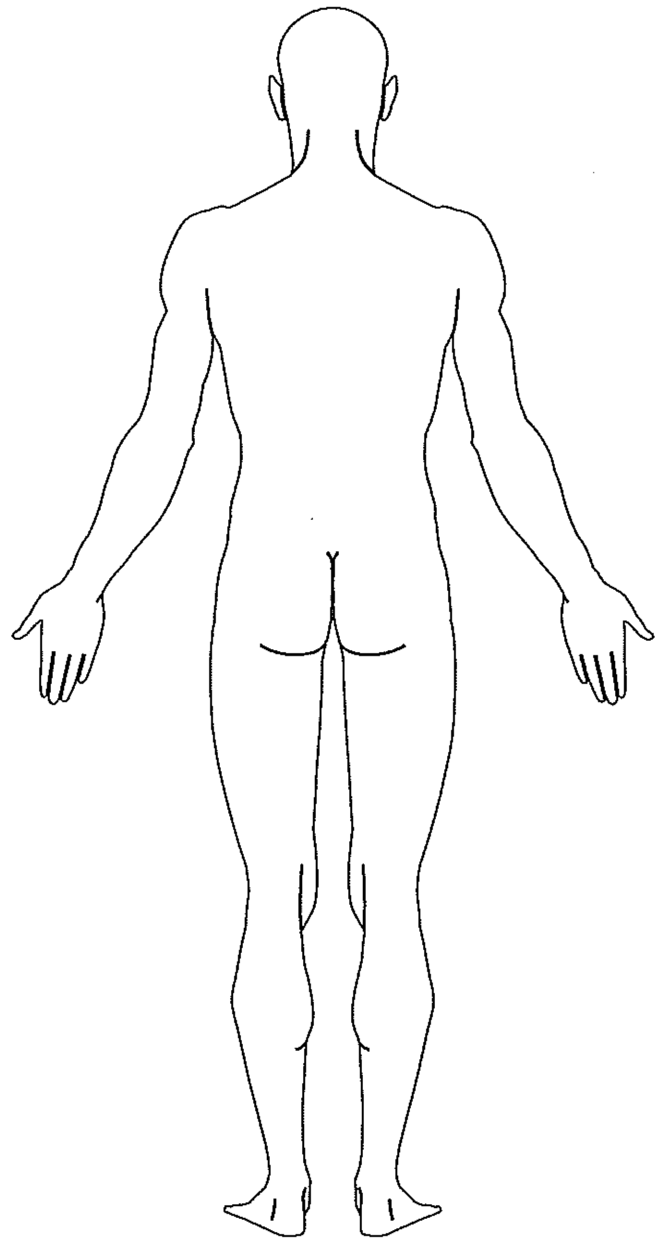
GENERAL SYMPTOMS CHART

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:

____

____

____

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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.*

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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.

____ Mid Back Pain
____ Nausea
____ Diabetes
____ Pain in Ribs/Chest
____ Ulcers/Gastritis
____ Hypoglycemia/Hyperglycemia
____ Indigestion/Heartburn
____ Reflux
____ 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.

____ Pain in hips/legs/feet
____ Weakness/injuries in hips/knees/ankles
____ Low back pain
____ Numbness/tingling in legs/feet
____ Recurrent bladder infections
____ Coldness in legs/feet
____ Frequent/difficulty urinating
____ Muscle cramps in legs/feet
____ Sexual dysfunction
____ Constipation/Diarrhea
____ 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): ______________________________

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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)***:

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

____ 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 ( ) ________________

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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 #: _____-_____ - _______

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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

Chiropractic Certification in Spinal Trauma

Dr. Albert G. Simoncelli, DC, CCST
and Associates

Member: International Chiropractic Association
Members: Nevada State Chiropractic Association

EXPLANATION OF NON-COVERED CHIROPRACTIC SERVICES FOR MEDICARE PATIENTS

DEDUCTIBLE:

Medicare requires you to pay a yearly chiropractic deductible of $110.00 towards your medical expenses. If you have already been treated by other doctors this year, you may apply those bills to your deductible.

WHAT MEDICARE WILL PAY FOR:

After you have met your yearly deductible, Medicare will reimburse 80% of "Allowable treatment charges". THE ONLY 'ALLOWABLE TREATMENT CHARGE" BY A CHIROPRACTOR IS "MANUAL MANIPULATION OF THE SPINE". Once Medicare has determined that further manipulative treatment is not 'reasonable or necessary" to restore your condition, you will then be responsible to pay for all of your treatment charges.

X-RAYS:

Medicare requires that you have current x-rays on your initial visit. By Medicare's regulations, "current" means "x-rays that are less than 12 months before or within 3 months after your initial visit". Medicare WILL NOT REIMBURSE for x-rays taken or ordered by a chiropractor, and therefore payment must be made by you.

EXAMINATIONS:

In order to determine the extent of your condition, as well as the type of treatment you will need, the doctor will do an examination prior to the initiation of treatment. Medicare WILL NOT REIMBURSE you for this examination, and payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS, AND SUPPORTS:

During the course of your treatment in this office, the doctor may determine that certain physical therapy, vitamin supplements and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare WILL NOT REIMBURSE you for any of these services, and payment must be made by you.

I understand that although the chiropractic services listed above may be required for treatment of my condition, these charges are not covered by Medicare and I will be personally responsible for payment of these charges.

Patient Signature______________________ **Date**______________________

9034 West Sahara Avenue
Las Vegas, Nevada 89117
702.256.8686

321 North Pecos Road Suite 200
Henderson, Nevada 89014
702.263.4925

Mountain West Chiropractic
Albert G. Simoncelli, DC CCST and Associates
9034 W. Sahara Ave. Las Vegas, NV 89117
702.256.8686 Fax: 702.256.2206

Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	NEW PATIENT EXAMINATIONS, ALL PROGRESS EVALUATIONS, X-RAYS, TRACTION, FLEXION DISTRACTION, EXERCISES, PNEUMEX, COLD LASER TREATMENT, ULTRASOUND, ELECTRICAL STIMULATION, ICE THERAPY, MASSAGE, ALL SUPPLIES AND SUPPLEMENTS		
Reason Medicare May Not Pay:	MEDICARE ONLY COVERS THE SPINAL ADJUSTMENT		
Estimated Cost:			

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed in the first box above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the services listed above. I may be asked to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the services listed above, but do not bill Medicare. I may be asked to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the services listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

Additional Information: This ABN form is only for non-covered Medicare services. Medicare never pays for such services. The only reason for using Option1 above is when you have secondary insurance that might reimburse you.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy if requested.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

Dr. Albert G. Simoncelli, DC, PC, CCST, and Associates
9034 W. Sahara Ave.
Las Vegas, NV 89117
702-256-8686

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: _____/_____

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: ______________

____
Patient's Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

Dated: ______________

____
Doctor's Name

____
Signature

Dr. Albert G. Simoncelli, DC, PC, CCST, and Associates
9034 W. Sahara Ave.
Las Vegas, NV 89117
702-256-8686

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