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. Improving our patients towards ideal spinal posture helps our patients recover to 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 what the underlying cause of your condition is. We will perform all necessary tests to establish an optimal diagnosis to determine what level of treatment is recommended. Once we have established that, we will be completely confident we can help you restore your health.

> "Health is not merely the absence of pain, but a 100% functional and vibrant mind and body"

Please understand that 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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Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Who may we thank for referring you into our office? ______________________________

Patient Name: ______________________________ S.S. #: ____________

Address: ______________________ City/State: ______________ Zip: ________

Home Phone: ______________ Work Phone: ______________

Birthdate: ____/____/____ Sex: M / F Weight:________ Height: ________

Names of parents / Guardians: ______________________________

PURPOSE FOR CONTACTING US:

Other doctor's seen for this condition? YES NO

If yes, Doctor's names & Prior treatments: ______________________________

____

Other health problems? ______________________________

Family health history:______________________________

Previous Chiropractor: ______________________________

Date of last visit: ____/____/____ Reason: ______________________________

Name of Pediatrician: ______________________________

Date of last visit: ____/____/____ Reason: ______________________________

Are you satisfied with the care your child has received there? YES NO

Number of doses of antibiotics your child has taken: ______

During the past 6 months: ______, total during his/her lifetime:________

Number of doses of other prescription medications your child has taken during the past 6 months: _____,
total during his/her lifetime:_____

Vaccination history: ______________________________

PRENATAL HISTORY

Name of obstetrician/Midwife: ______________________________

Complications during pregnancy? YES NO If yes, list: ______________________________

Complications during delivery? YES NO If yes, list: ______________________________

Ultrasounds during pregnancy? YES NO If yes, number:________

Medications during pregnancy/delivery: YES NO If yes, number:________

Location of birth: HOSPITAL BIRTHING CENTER HOME

Birth intervention: FORCEPS VACUUM EXTRACTION

CESSARIAN SECTION - EMERGENCY or PLANNED?

Apgara scores ______,_______ Cigarette/Alcohol use during pregnancy? YES NO

Genetic disorders or disabilities? YES NO If yes, list: ______________________________

Birth Weight:_________ Birth Length: _________

FEEDING HISTORY

Breast fed? YES NO If yes, how long? __________ Formula fed? YES NO If yes, how long? __________

Introduced solids at: _____ months, cow's milk at _________ months

Food/juice allergies or intolerances? YES NO If yes, list? __________

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound

_____ Respond to Visual Stimuli

_____ Sit Up

_____ Cross Crawl

_____ Stand Alone

_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, a changing table, down stairs, etc.) Was this the case with your child? YES NO

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? YES NO If yes, list: __________

Has your child ever been involved in a car accident? YES NO If yes, list: __________

Has your child ever been seen on an emergency basis? YES NO If yes, list: __________

Other traumas not described above? YES NO If yes, list: __________

Prior surgery? YES NO If yes, list: __________

Menarche? YES NO If yes, list: __________

CHILDHOOD DISEASES

Chicken Pox YES NO If yes, age: _______

Rubella YES NO If yes, age: _______

Rubeola YES NO If yes, age: _______

Mumps YES NO If yes, age: _______

Whooping Cough YES NO If yes, age: _______

Other YES NO If yes, age: _______

We are here to serve you and encourage you to ask questions, your participation is vital and will help determine your results.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: __________________________ Policy #: __________________

Signed: ____

Witnessed: ____

Date: ______ / ______ / ______

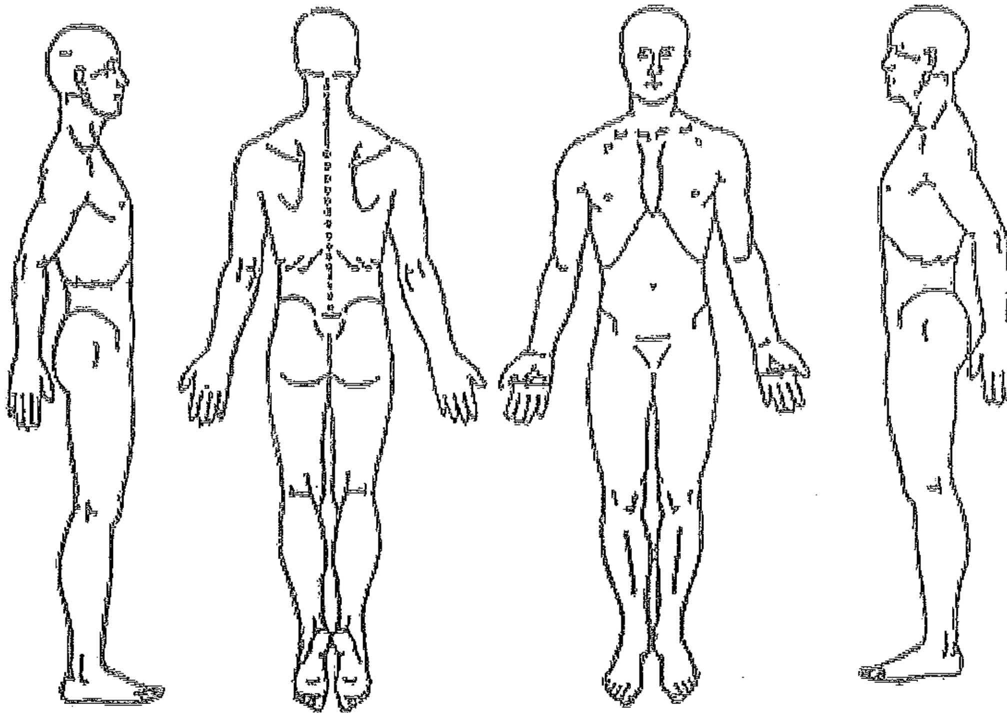
GENERAL SYMPTOMS CHART

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
B = BURNING
ST = STABBING
T = TINGLING

F = STIFFNESS
SP = SPASMS
N = NUMBNESS

P = PINS & NEEDLES
O = OTHER



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

____

____

____

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PA-Gr043011

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
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Diabetes
____ Hypoglycemia/Hyperglycemia
____ 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
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Constipation/Diarrhea
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Menstrual irregularities/cramping (females)
____ Low back pain
____ Coldness in legs/feet
____ Sexual dysfunction

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 Mountain West Chiropractic 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____

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