ChiroHealth

210 West Florence Blvd. • Casa Grande, AZ 85122 PO Box 10956 • Casa Grande, AZ 85230 (520)876-5500

WELCOME TO OUR OFFICE

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:______________________ SOCIAL SECURITY #:______________ DATE:__________

DATE OF BIRTH:__________ AGE:___ SEX: M F MARITAL STATUS: M S D W # OF CHILDREN:___

ADDRESS:____

CITY:______________________ STATE:__________ ZIP:______________

HOME PHONE #:____________________ CELL PHONE #:____________________

E-MAIL ADDRESS:____________________ OCCUPATION:____________________

COMPANY NAME:____________________ LENGTH OF EMPLOYMENT:______________

TYPE OF WORK: OFFICE/CLERICAL LIGHT LABOR MODERATE LABOR HEAVY LABOR

SPOUSES NAME:______________________________

IN CASE OF EMERGENCY CONTACT NAME:______________ HOME PHONE #:______________

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge.
I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:______________________________

INSURANCE COMPANY:______________________ PHONE :______________________

GROUP #:______________________ ID :______________________

Patient / Guardian Signature ______________________ Date______________

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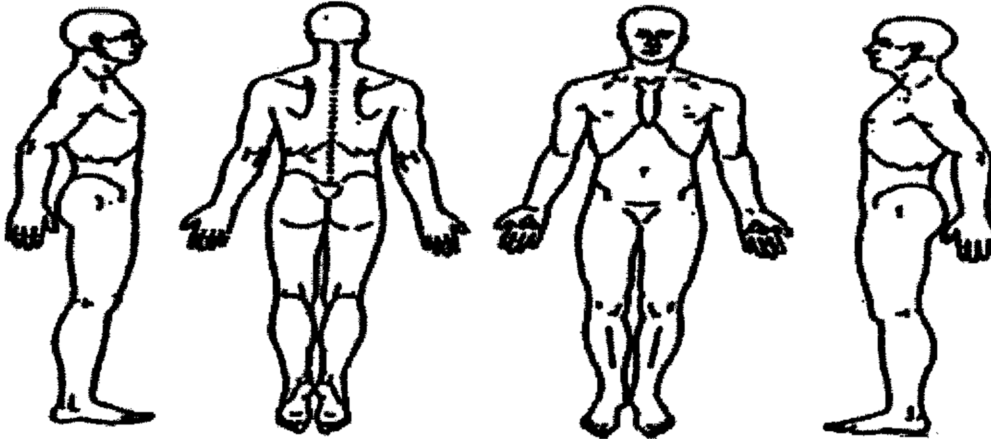
1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - □ Constantly (76-100% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51-75% of the time)
   - □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - □ Sharp
   - □ Numb
   - □ Dull
   - □ Tingly
   - □ Diffuse
   - □ Sharp with motion
   - □ Achy
   - □ Shooting with motion
   - □ Burning
   - □ Stabbing with motion
   - □ Shooting
   - □ Electric like with motion
   - □ Stiff
   - □ Other:_______________

5. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ Neurologist
   - □ Primary Care Physician
   - □ ER physician
   - □ Orthopedist
   - □ Other:___________
   - □ Massage Therapist
   - □ Physical Therapist
   - □ No one

10. How long have you had this problem? __________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height__________ Weight ___________ Dominant Hand: Right or Left

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16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Hypertension
□ Heart Problems □ Cancer □ ALS □ Stroke

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:________________				

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?
□ Sit: □ Most of the day □ Half the day □ A little of the day
□ Stand: □ Most of the day □ Half the day □ A little of the day
□ Computer work: □ Most of the day □ Half the day □ A little of the day
□ On the phone: □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?______________________________

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1. What was the date of the accident?____________________
2. What time did the accident occur?____________________
3. How many vehicles were involved in the accident?____________________
4. What was the estimated damage to the vehicle you were in? ____________________
5. What state did the accident occur in? ____________________
6. What city did the accident occur in? ____________________
7. What street or intersection were you on when the accident occured? ____________________
8. What direction were you traveling in? ____________________
9. What type of impact was the auto accident? ____________________
10. Did your vehicle hit anything after the accident? if yes, please describe
____
11. Where were you sitting in the vehicle during the accident? ____________________
12. Did you know the accident was coming?____________________
13. What type of vehicle were you in? ____________________
14. What type of vehicle impacted yours? ____________________
15. At the time of the impact, how fast was your vehicle moving? ____________________
16. At the time of impact, how fast was the other vehicle moving? ____________________
17. During and after the crash what happened to your vehicle? (circle all that apply)
    - kept going straight - spun around
    - kept going straight hitting a car in front - spun around and hit a stationary object
    - was hit by another vehicle - hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? ____________________
20. How was your torso positioned during the accident? ____________________
21. How were your hands positioned during the accident? ____________________
22. Did your head hit anything during the accident? -no - yes, please describe____________
23. Did your face hit anything during the accident? -no - yes, please describe____________
24. Did your shoulders hit anything during the accident? -no - yes, please describe____________
25. Did your neck hit anything during the accident? -no - yes, please describe____________

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26. Did your chest hit anything during the accident? -no - yes, please describe_______________

27. Did your hips hit anything during the accident? -no - yes, please describe_______________

28. Did your knees hit anything during the accident? -no - yes, please describe_______________

29. Did your feet hit anything during the accident? -no - yes, please describe_______________

30. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - nonmovable fixed headrest
    - no headrest

31. Where was the headrest positioned on your head? _______________

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _______________

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
    - floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
    - front left - front right
    - rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43 _______________

38. How did get to the hospital? _______________

39. What was the name of the hospital? _______________

40. Were you hospitalized overnight? _______________

41. Circle what you were prescribed at the hospital
    - pain medication - muscle relaxers - neck brace

42. Did you receive any stitches for any cuts at the hospital? _______________

43. Were x rays taken at the hospital? If yes, which area was taken?

____

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

RE: ______________________________

DOB: ______________________________

I hereby grant permission to ChiroHealth LLC to release or obtain any medical records needed to evaluate my condition or treatment.

Mail to:

ChiroHealth LLC
PO BOX 10956
CASA GRANDE, AZ 85230
FAX: 480-393-4613

I also authorize ChiroHealth LLC to release medical records, and /or medical bills, for services rendered to any insurance company, whether pursuant to medical payments coverage, health insurance or liability coverage, as long as I have an outstanding balance with them. I further authorize any insurance company to provide insurance and status information to ChiroHealth LLC.

I understand that I may revoke this authorization at nay time providing I notify ChiroHealth LLC in writing. This authorization is valid for three years from the date it is signed by me.

Patient's Signature: ______________________________

Date: ____________________

IF A MINOR – SIGNATURE OF PARENT OR LEGAL GUARDIAN REQUIRED BELOW:

Signed: ______________________________ For: ______________________________
(Signature of Parent or Guardian) (Patient's Name)

A photocopy of this original is to be treated as an original.

Send information to the address listed above.

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DISCLOSURE OF FEES/PAYMENT POLICY

99201	New Patient Evaluation and Management	$ 79.00
99202	New Patient Evaluation and Management	$ 95.00
99203	NP-Detailed History and Examination	$125.00
99211	Established Patient Office Visit	$ 40.00
99212	Established Patient Office Visit	$ 70.00
99213	Est Pt-Expanded History and Examination	$ 75.00
98940	Chiropractic Spinal Manipulation 1-2 Regions	$ 40.00
98941	Chiropractic Spinal Manipulation 3-4 Regions	$ 50.00
97140	Manual Therapy	$ 39.00
97010	Hot and Cold Packs	$ 25.00
97012	Mechanical Traction	$ 29.00
97014	Electrical Stim.	$ 29.00
97035	Ultrasound	$ 33.00
97530	Therapeutic Activities - per unit	$ 48.00
97110	Therapeutic Procedure - per unit	$ 50.00
97112	Neuromuscular Reeducation - per unit	$ 50.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check is returned for insufficient funds, I will be charged a $25.00 service charge.

I further understand that if my insurance company declines payment, I authorize ChiroHealth LLC to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed____ Date_______________

Informed Consent to Chiropractic Treatment

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The Nature of the Chiropractic Adjustment

We will use our hands or a mechanical device upon your body in such a way to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you crack your knuckles. You may feel or sense movement.

The Material Risks Inherent in Chiropractic Adjustment

As with any health care procedures, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injures, dislocations, muscle strain, cervical myelopathy and costovertebral strain and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone or bone disease, which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such and outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

The Availability and Nature of Other treatment Options

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain relievers
- Hospitalization with traction
- Surgery

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Included:

Overuse of the over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patent's general health, severity of the patient's discomfort, his/her pain tolerate, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain relieves can produce undesirable side **effects and patients dependence**. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/ her pain tolerance, and self-discipline in not abusing the medicine, and proper professional supervision. Such medications generally very significant risks—some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor injured) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain, and exposure to communicable disease is likely with adverse result from such expose dependent upon unknown variables.

The risk inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalizations and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. In addition, compromise to your neurophysiological integrity and health of your nervous system will continue. Over time, these processes may complicate treatment, making the treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

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 my doctor 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 myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to CHIROHEALTH LLC and Nephi Riordan, D.C. to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

______________________	______________________
Date	Patient Printed Name
______________________	______________________