Patient Information

About You

Todays Date: _____/_____/_____
Name: _____
Preferred to be called: _____ ❑ Male ❑ Female
Birthdate: _____/_____/_____ Age: _____ SS#:_____-____-_____
Home Address:_____
Apt/Suite/Townhouse #: _____
City: _____ State: _____ Zip: _____
Phones Home/cell: (____)_____ Cell phone carrier: _____
Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____ Work #: (_____)_____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
Spouses name: _____ Phone: (_____)_____
Emergency Contact: _____ Phone: (_____)_____

Reason for Visit

Have you ever been treated by a chiropractor before? ❑ Yes ❑ No
If so, please explain:_____
The reason for this visit is a result of (Please circle): Work Sports Auto Trauma or Chronic
(Explain what happened): _____
_____
Please describe the pain & its location: _____
_____
When did the condition begin? _____/_____/_____
Is the condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes
Is this condition interfering with your (Please circle): work sleep daily routine
If so, please explain:_____
Have you been treated by a Medical Physician for this condition: ❑ Yes ❑ No
If so, where? _____

Please list medications and dosage -if you have a list please give to receptionist

Health History

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin ❑ Muscle relaxers ❑ Stimulants ❑ Blood thinners ❑ Tranquilizers ❑ Insulin

Have you ever had any of the following diseases/medical condition(s)?

Y	N	Heart Attack/Stroke	Y	N	Heart Surg./Pacemaker	Y	N	Heart Murmur
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N	Artificial Valves
Y	N	Alcohol/Drug Abuse	Y	N	Venereal Disease	Y	N	Hepatitis
Y	N	HIV+/AIDS	Y	N	Shingles	Y	N	Cancer
Y	N	Frequent Neck Pain	Y	N	Emphysema/Glaucoma	Y	N	Anemia
Y	N	High/Low Blood Pressure	Y	N	Psychiatric Problems	Y	N	Rheumatic Fever
Y	N	Severe/Frequent Headaches	Y	N	Kidney Problems	Y	N	Ulcers/Colitis
Y	N	Fainting/Seizures/Epilepsy	Y	N	Sinus Problems	Y	N	Asthma
Y	N	Diabetes/Tuberculosis	Y	N	Difficulty Breathing	Y	N	Chemotherapy
Y	N	Lower Back Problems	Y	N	Artificial Bones/Joints	Y	N	Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

_____

Please list anything you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

_____

List any past serious accidents with dates: _____

_____

_____

Do you smoke? ❑ No ❑ Yes/How much? _____ How long? _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

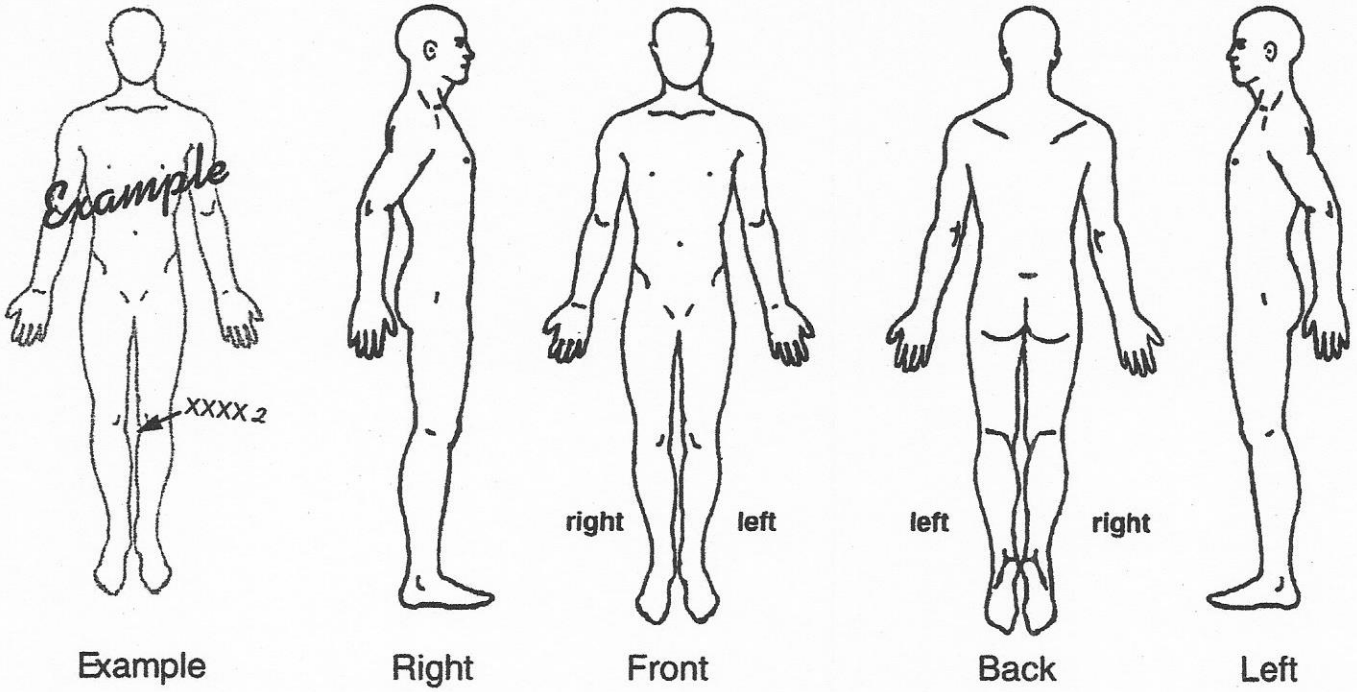
Are you pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ Yes ❑ No

Pain Chart

Show Us Where IT Hurts

Please mark **area(s)** of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	ΛΛΛΛΛ	XXXXX	●●●●●



Example Right Front Back Left

Authorization to perform x-rays and consent for treatment

If the doctor recommends that x-rays be taken to complete the study and analysis of my current condition, I give my consent. I also give the doctor consent to administer whatever treatment is deemed necessary to treat my problem or illness. If applicable, to the best of my knowledge I am NOT pregnant, and the doctor has my permission to x-ray me for diagnostic interpretation. I also authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and I understand that it is my responsibility to inform this office of any changes to my medical status including my medical insurance companies.

❑ **I AM PREGNANT** Due Date _____/_____/_____

-thus I **will not** be getting an x-ray but agree to all of the above with this one exception.

Signature _____ **Date** _____

Witness _____

Eastside Chiropractic Clinic

2821 Hubbell Ave.

Des Moines, IA 50317

Effective Date: [April 14, 2003]

Notice of Privacy Practices – Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting the Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)

This form will be retained in your health record.

This information is subject to change without written notice:

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

The summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Eastside Chiropractic Clinic uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

Eastside Chiropractic Clinic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Eastside Chiropractic Clinic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Eastside Chiropractic Clinic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filling a complaint.

Eastside Chiropractic Clinic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to you health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction of how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints please contact the Office Manager at 515-263-1313.

_____ _____

Patient Signature Date

Patient Waiver and Affirmation of Financial Responsibility for Professional Services Rendered

The Doctor's and staff have informed me that the professional services I am requesting today **may not** be a covered benefit as defined by my health insurance policy. I have decided to receive the recommended services. I am aware these services **may not** be covered for the duration of my treatment for this condition or may be deemed a non-covered service or experimental. **I agree to be financially responsible for these services.**

Professional services that may be recommended for me that may not be covered: ♦Any spinal adjustment or therapy administered for specific condition for which I am undergoing care. This may include additional therapies administered for a specific condition for which I am undergoing care may include electrical stimulation, hot or cold packs, cervical traction, lumbar traction, decompression therapy, myofascial therapy or any other physical medicine procedure. ♦Radiographic procedures necessary for the proper evaluation of your condition. ♦Initial or follow-up examination procedures necessary to monitor your progress or assess any new symptoms you may experience.

I agree to be financially responsible for services provided by the doctor's and his staff. This agreement shall remain in force until revoked in writing.

_____My initials act as my signature

Eastside Chiropractic Clinic Financial Policy

It is our position that a clear financial policy allows our patients to understand their financial obligations- which enables them to continue with the care needed to achieve the level of health they desire.

- All deductibles, co-pays, co-insurance, or cash balance owed by the patient is due at the time of service or at the end of each week.
- Since insurance companies do not consider verification of benefits a guarantee of payment, the patient accepts responsibility for full payment of any and all services rendered. If your insurance company has for some reason did not pay a claim within 60 days of submission, you agree to take an active part in the recovery of the claim. We have highly trained staff to assist you in dealing with third party payers. Please bring us any correspondence from your insurance company. We will be glad to help you complete it.
- An insurance company will sometimes reject a claim as medically unnecessary. Should this happen, you will pay for any services which have been denied. Medically Necessary means the shortest, least expensive, or least intense level of treatment, care, or services rendered, or supply provided, as determined by the insurance company, to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition, is known to be safe and effective by most doctors who are licensed to treat the condition at the time the service is rendered, and is not provided primarily for the convenience of the insured person or doctor.
- A finance charge of 1½% per month will be calculated upon the unpaid cash balance each month. To avoid paying finance charges, the cash balance must be paid before the next billing cycle, which begins the first of each month.
- This agreement authorizes and directs your insurance company or attorney to pay directly to this office any sums that are owed for services rendered to you.
- I authorize Eastside Chiropractic Clinic to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection of my outstanding account. I agree that this office be given power of attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Printed name_____ Date_____

Signed name_____ Witness_____