CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. Thank you.

Name _____ Nickname _____ Birthdate _____ Sex: F M

Address _____ City/State _____ Zip _____

Soc. Sec # _____ Home # _____ Work _____ Cell _____

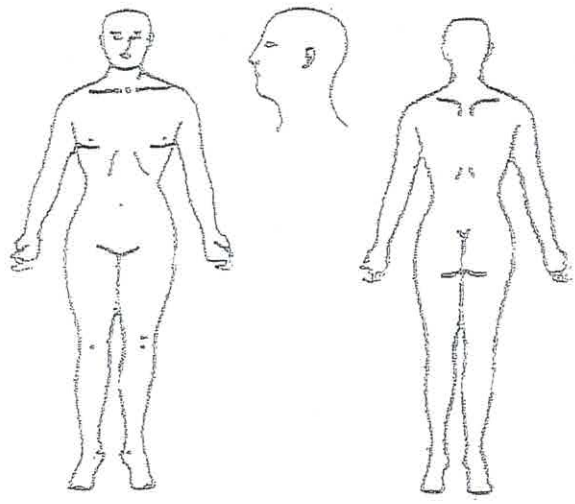
Marital Status: M D S W Spouse's Name _____

Occupation _____ Employer _____

How did you hear about us? _____ E-mail _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ·ooo Stabbing ////



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

_____

None Most Severe

How bad have they been in the past?

_____

None Most Severe

What services interest you? (mark all that apply)

- ☐ balance, coordination training, and strengthening
- ☐ range of motion, mobility, or flexibility therapy
- ☐ spinal & body alignment
- ☐ acupuncture
- ☐ nutritional & supplement counseling
- ☐ other: _____

*Female Patients: Is there a possibility you could be pregnant? No Yes Possible Due Date _____

Have you had breast implant surgery? No Yes Do you have a pacemaker? No Yes

Have you had knee or hip replacement surgery? No Yes Describe _____

Do you have any other implantable medical devices in your body? No Yes Describe _____

Do you have a family physician? Name _____

Have you ever been treated by a Chiropractor? No Yes

If yes, by whom? _____ Phone # _____

The reason for the visit: _____

Have you been in an auto accident or had any other personal injury? No Yes Describe _____

_____

In case of emergency, please contact: _____ Relationship _____

Phone # _____

Signature _____ Date _____

Patient Medical History

	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint
1. When and how did this condition begin? (fall, accident, while lifting, etc)				
2. Location of Pain: (ie: low back, neck, headache, etc)				
3. How much of your day do you feel pain?	0%-25%-50%-75%-100%	0%-25%-50%-75%-100%	0%-25%-50%-75%-100%	0%-25%-50%-75%-100%
4. Pain level? (0 being no pain and 10 being worst pain)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5. How would you describe your pain? (burning, sharp, throbbing, ache, etc)				
6. Does the pain radiate? (down the legs, into the arms, etc)				
7. What makes your condition worse? (positions or activities that hurt)				
8. What makes your condition better? (positions or activities that help)				
9. Previously attempted remedies? (stretching, ice/heat, medication, etc)				

10. Do you smoke? [Yes] [No] [Former Smoker] If former smoker, what year did you quit? _____

17. How much do you or did you smoke: [less than 1 a pack] [1-2 pack a day] [2+ packs a day] [3+ packs a day] (circle one)

18. Alcohol use: [None] [Former] [Rare] [Mild] [Moderate] [Severe] (circle one)

19. Activity Level: [Light] [Moderate] [Sedentary] [Vigorous]

20. Hospitalizations _____

21. Surgeries _____

22. Accidents/Injuries _____

23. Previous/Ongoing Illnesses _____

24. Allergies: _____

25. Current Medications:

Medication	Reason for taking

26. Family History _____

27. Employment: [Student] [Disabled] [Unemployed] [Employed _____] [Retired_____]

28. **Previous Tests:** _____

29. **Medical Procedures** _____ **Pacemaker/Defibrillator?** **Yes** **No**

30. **Nutritional Supplements** _____

31. **Prior Chiropractic Care** _____

I have read the above information and certify it to be true and correct to the best of my knowledge. I have had an opportunity to discuss my medical history and any concerns with the doctor and hereby authorize First Chiropractic to provide me with chiropractic care, physical medicine, therapeutic modalities, and/or acupuncture, in accordance with Arizona state statutes.

Patient (Guardian) Signature _____ **Date** _____

Doctors Signature _____ **Date** _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

FINANCIAL POLICY
FIRST CHIROPRACTIC
1868 HIGHWAY 95
BULLHEAD CITY, AZ 86442

- It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

- All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $100 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

- For your convenience, this office accepts cash, checks, and the following credit cards:
Visa, MasterCard, American Express, Discover

- This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.

- Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.

- Any balance left unpaid after a period of 90 days will be assessed an interest charge of 1.5 percent per month.

- As a courtesy to our patients, this office will file claims to Worker's Compensation Fund, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. Upon the end of treatment, it is the patient's financial responsibility for any unpaid portion. At the beginning of treatment, a Lien is filed with the Mohave County Recorder's Office. This lien will be in effect until all remainder balance due is paid. From the date of your release from treatment, you will accrue an interest rate of 1.5 percent every thirty days until the balance due is paid.

- As a courtesy to our patients, this office will file claims to Third Party Auto Injury Insurance and Medical Payment Policies, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. Upon the end of treatment, it is the patient's financial responsibility for any unpaid portion. At the beginning of treatment, a Lien is filed with the Mohave County Recorder's Office. This lien will be in effect until all remainder balance due is paid.

- The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

- No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

- If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 90 days the balance becomes due and payable immediately and your assignment is revoked.

- All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care.

- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: _____ Date: _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ Patient's Name (Print)

_____ Patient's Signature

_____ Date

_____ Relationship or authority if not signed By patient

_____ Witness

First Chiropractic

Derek Price, DC **Kara Holden, DC**
1868 Hwy 95, Bullhead City, AZ 86442
Phone: 928-763-8313 Fax: 928-763-7995

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____
Patient Signature

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ consent to allow First Chiropractic or representative thereof to discuss or share medical information (including but not limited to calling to inquire appointment dates, treatment dates, medical progress, etc.) with the following people.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying First Chiropractic in writing.
2. I understand that I can refuse to sign this authorization and the refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3. I may inspect or copy any information used or disclosed under this agreement
4. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
Patient Signature Date

First Chiropractic

Derek Price, DC **Kara Holden, DC**
1868 Hwy 95, Bullhead City, AZ 86442
Phone: 928-763-8313 Fax: 928-763-7995

Authorization for Disclosure of Health Information

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
PURSUANT TO 45 CFR 164.508

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

_____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State, Zip Code

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: (CHECK ALL THAT APPLY)

__ Complete Medical Records __ Medical History, Evaluation Records __ Immunizations
__ Treatment or Tests __ Hospital Records Including Reports __ X-Ray Reports
__ Allergy Records __ Laboratory Reports __ MRI/ CT Scan
__ Consultation Documentation __ Surgical Reports __ Prescription Data
__ Other (Specify):_____

I also specifically authorize that any sensitive information regarding (check all that apply)
__ HIV/AIDS__ Substance Abuse (alcoholism or drug) Mental Health to be released to the above referenced

It is my understanding that the information to be released will be used for the following purposes (check all that apply)

__ At the request of the individual (no purpose need be specified) __ Change of Provider
__ Additional Medical Care __ Legal Investigation or Action __ Insurance Eligibility/ Benefits
__ Other (Specify):_____

I understand that if the authorized recipient is not a provider, health plan or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

INDIVIDUALS RIGHTS RELATING TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization or to receive a copy of my revocation, I am to contact: Derek Price at (928)763-8313). I am aware that my revocation will not be effective as to uses, and /or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPERATION DATE: Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

I have had an opportunity to review and understand the content of this Authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____
Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi)