AMERICAN CHIROPRACTIC CENTER

Please Print Neatly

Name _____ Age_____ Sex: M_____ F_____ Date_____

Address_____ City_____ State_____ Zip _____

Home ( ) _____ Birth Date _____ Social Security # _____

Cell Phone _____ Patient's Email Address _____

Occupation _____ Employer _____ Work Phone _____

To Whom May We Thank for Referring You? Patient_____

SBC Phone Book _____ Yellow Pages _____ Internet _____ Other _____

In Case of Emergency, whom should we notify? _____

Phone _____ Relationship _____

Name of Insurance _____ Name of Insured _____ Insured DOB _____

I do not have insurance _____

Your Medical Doctors _____ City _____ Last Visit _____ Reason:_____

_____ City _____ Last Visit _____ Reason:_____

Have you ever been to a chiropractor? Yes _____ No _____ Name of chiropractor _____

Last treatment date: _____ REASON:

Results were: Favorable _____ No Improvement _____

I acknowledge that a "Notice of Privacy Practices" is available for my review: (Patient Initials) _____

My current injury is related to: Work _____ Auto _____ Neither _____ Patient Initials: _____

Please describe your major complaints and symptoms that you are here for:

Date you first noticed the problem:_____ Is it better? Yes No **Is it getting worse?** Yes No

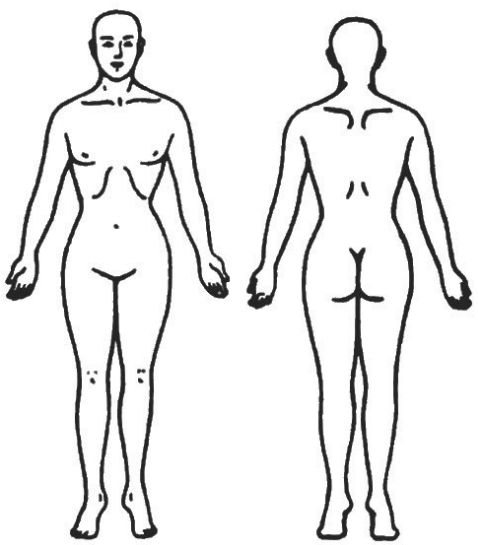
Has it stayed the same? Yes No **It started** *Gradually Rapidly* **Have you noticed the problem before?** Yes No

If so, when? _____ Was it this bad? Yes No **What, if anything gives you relief? _____**

Was there anything specific that started this? _____

Does the pain keep you up at night? Yes No **Does a certain position give you relief?** Yes No **What? _____**

Please X or Circle areas of pain or injury on the illustrations below and give a word description of the major symptoms and major complaints you are experiencing in those areas.



TURN PAGE OVER

Case History

Please mark the applicable boxes you now have or have had in the past.

☐ ☐ ☐ ☐ **1) Had but no longer an issue 2) Have Occasionally 3) Have Frequently 4) Have Constantly**
1 2 3 4

☐ ☐ ☐ ☐ Allergies_____
☐ ☐ ☐ ☐ Seizures/Convulsions---Grand Mal / Petite Mal
☐ ☐ ☐ ☐ Dizziness Fainting Lightheadedness
☐ ☐ ☐ ☐ Headaches (use head diagram)
☐ ☐ ☐ ☐ Loss of feeling _____
☐ ☐ ☐ ☐ "Pins & Needles"_____
☐ ☐ ☐ ☐ Psychiatric Problems_____
☐ ☐ ☐ ☐ Osteoarthritis (where?) _____
☐ ☐ ☐ ☐ Bursitis (where?)_____
☐ ☐ ☐ ☐ Foot problems (what?) _____
☐ ☐ ☐ ☐ Lower back pain
☐ ☐ ☐ ☐ knee pain Left Right
☐ ☐ ☐ ☐ Artificial joints (where?) _____
☐ ☐ ☐ ☐ Neck pain and/or Neck stiffness
☐ ☐ ☐ ☐ Tight shoulders or between shoulder blades
☐ ☐ ☐ ☐ leg pain / sciatica (burns--tingles--sharp)

☐ ☐ ☐ ☐ Shoulder pain LEFT RIGHT
☐ ☐ ☐ ☐ Elbow pain LEFT RIGHT
☐ ☐ ☐ ☐ Wrist pain LEFT RIGHT
☐ ☐ ☐ ☐ Hip pain LEFT RIGHT
☐ ☐ ☐ ☐ Knee pain LEFT RIGHT
☐ ☐ ☐ ☐ Ankle pain LEFT RIGHT

☐ ☐ ☐ ☐ Colon problems_____
☐ ☐ ☐ ☐ Constipation
☐ ☐ ☐ ☐ Diarrhea
☐ ☐ ☐ ☐ Indigestion / Heartburn
☐ ☐ ☐ ☐ Ulcers - - Gastric or Duodenal
☐ ☐ ☐ ☐ Gas / flatulence
☐ ☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ ☐ Liver problems: Type_____ Hepatitis Cirrhosis
☐ ☐ ☐ ☐ Autoimmune Disorders_____
☐ ☐ ☐ ☐ Skin rashes _____

☐ ☐ ☐ ☐ Asthma
☐ ☐ ☐ ☐ Bronchitis
☐ ☐ ☐ ☐ Sinus Infections
☐ ☐ ☐ ☐ Colds
☐ ☐ ☐ ☐ Ear Infections
☐ ☐ ☐ ☐ Tinnitus (Ear noises / Ringing)
☐ ☐ ☐ ☐ Nose bleeds
☐ ☐ ☐ ☐ Shingles

☐ ☐ ☐ ☐ High blood pressure
☐ ☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ ☐ High cholesterol #_____
☐ ☐ ☐ ☐ Hardening of the arteries
☐ ☐ ☐ ☐ Chest pain (when) _____
☐ ☐ ☐ ☐ Poor circulation
☐ ☐ ☐ ☐ Bruise easily
☐ ☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ ☐ Swelling (ankles / feet / hands)
☐ ☐ ☐ ☐ Chronic cough (since)_____
☐ ☐ ☐ ☐ Difficulty breathing
☐ ☐ ☐ ☐ Wheezing
☐ ☐ ☐ ☐ Spitting up: Blood Phlegm
☐ ☐ ☐ ☐ Varicose veins
☐ ☐ ☐ ☐ Pneumonia (Bacterial Viral)
☐ ☐ ☐ ☐ Pneumonia (Pneumocystic)

☐ ☐ ☐ ☐ Bed wetting
☐ ☐ ☐ ☐ Blood in urine
☐ ☐ ☐ ☐ Frequent urination _____x's /day
☐ ☐ ☐ ☐ Bladder incontinence
☐ ☐ ☐ ☐ Kidney (Stones Infections)
☐ ☐ ☐ ☐ Painful urination
☐ ☐ ☐ ☐ Foul smelling urine
☐ ☐ ☐ ☐ Prostate problems PSA_____#

Please list any drugs that you routinely take _____

Please list any past surgeries and when _____

_____

Have you ever been knocked unconscious? Y N When? _____ Why? _____
Have you ever used a crutch or cane? Y N When? _____ What for? _____
Have you been treated for a spine or nerve disorder? Y N When _____ What for? _____
Have you had any fractures? Y N When? _____ What? _____
Have you ever been Hospitalized? Y N When? _____ What for? _____
List any past serious accidents. When? _____ What? _____

DATE OF LAST:

Complete physical _____
Blood tests _____
Urine tests _____
Chest x-ray _____
Spinal x-rays _____
Dental x-rays _____
Eye exam _____

HABITS: (what & quantity)
Alcohol _____
Coffee # cups / day _____
Tobacco _____# / day ____

☐ ☐ ☐
1 2 3

1) Have 2) Had 3) Family Member

☐ ☐ ☐ Alcoholism ☐ ☐ ☐ Asthma ☐ ☐ ☐ Cancer _____ ☐ ☐ ☐ Diabetes ☐ ☐ ☐ Emphysema
☐ ☐ ☐ Heart Disease or Attack ☐ ☐ ☐ Multiple Sclerosis ☐ ☐ ☐ Rheumatic Fever ☐ ☐ ☐ Stroke
☐ ☐ ☐ Tuberculosis ☐ ☐ ☐ HIV AIDS date diagnosed _____ ☐ ☐ ☐ _____
☐ ☐ ☐ Drug Abuse Pregnant Yes No Osteoporosis Yes No

I am interested in more information regarding: ☐ Decompression Therapy ☐ Acupuncture ☐ Massage Therapy

My signature verifies that the information above is true and completely accurate _____

Print Name:_____ Date_____

American Chiropractic Center

738 32nd Street SE
Grand Rapids, MI 49548
(616)243-1444

0-81 Lake Michigan Dr. NW
Grand Rapids, MI 49534
(616)453-4308

Financial Policy

Thank you for choosing American Chiropractic Center as your pathway to wellness. We are committed to providing you with the best treatment possible, on a mutually agreed basis.

Billing and Insurance: Our professional relationship is with you, and not with any insurance carrier. You are responsible for paying the full cost of treatment when rendered unless covered by insurance. We participate with most major insurance companies and we will submit all authorized claims to the designated insurance carrier, provided we have received all required information prior to the initial treatment. For your convenience, we will request verification of your co-pays and deductible from your insurance carrier prior to your visit. It is your responsibility to make required payments at the time of each treatment (we accept cash, personal check, Visa, MasterCard, and Discover). We will charge a $25.00 fee for any returned checks. Note that quoted deductibles and co-pays are provided by your insurance carrier as estimates only, and do not guarantee payment by your insurance carrier. Some services or treatments might not be a covered benefit under your group plan or other insurance. You are responsible for payment of any services of treatments not covered by insurance carrier. It is also your responsibility to track deductibles, out of pockets, and maximum limits. It is your responsibility to establish preauthorization from your primary care physician if your insurance carrier requires you to do so prior to your first visit to evaluate and treat. Past Due Accounts: Accounts not paid within 30 days are considered past due. You are responsible for payment of any costs we incur in collecting past due accounts (such as collection agency and attorney fees).

Workers Compensation and Auto Accident Claims: You are responsible for payment for any treatment not covered by Workers' compensation or Michigan No-Fault. If your treatment is for an injury or illness covered by workers' compensation, you will not be billed for any amount being disputed through an insurance carrier's utilization review program or which exceeds the maximum amount permitted by the State. If your treatment is covered by Michigan No-Fault (auto) insurance, only the responsible insurance carriers will be billed.

I understand and agree to the terms of this Financial Policy. I authorize American Chiropractic Center to bill my insurer(s) for services rendered and I authorize my insurer(s) to make payment directly to the American Chiropractic Center for such services.

_____ _____

Signature of Responsible Party (must be over 18) Date

Payment Authorization: (Initials require for all three statements):

_____ **Assignment of Insurance Benefits**
I authorize that the payment of my insurance benefits be made directly to American Chiropractic Center For all services delivered; if I am paid directly I will promptly pay American Chiropractic Center all monies paid to me.

_____ **Guarantee of Payment**
I understand that all payments designated as "the patients' responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.

_____ **Assignment of Insurance Benefits**
I certify that the information I have provided American Chiropractic Center payment including but not limited to related accidents, illnesses or other insurers is accurate and truthful.

Acknowledgement of Receipt of Privacy Notice

This Acknowledgement which allows the Practice to use and/or disclosure identifiable health information for treatment, Payment or healthcare operations, is made pursuant to the requirements of 45 CFR 164.520©(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by **American Chiropractic Center** (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosures. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the Compliance Officer at American Chiropractic Center.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Privacy notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purpose of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed and executed copy of acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected Health Information for treatment, payment and healthcare operations.

_____ _____

Signature of Patient or Representative Date

Patient Authorization for Practice to Obtain or Release Protected Health Information

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR 154.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes American Chiropractic Center to obtain, use and disclose the personally identifiable health information specifically referenced in this Authorization.

_____ _____

Name of Person(s) Relationship to Patient

_____ _____

By signing this information, I acknowledge that I have reviewed this authorization and agree to the practice's use and disclosure of my protected health information for the purpose set forth within this authorization.

_____ _____

Signature of Patient/Parent/Guardian Date