RUBY MOUNTAIN
chiropractic center

Welcome,

Congratulations for choosing Ruby Mountain Chiropractic Center for your healthcare needs. Many people in, and around, Elko have been excited and pleased with the life-changing care they have received. Relax, you are in good hands.

Paperwork is always tedious but please take a few moments to complete these important documents that provide vital information about you, your pain/complaint and your goals in care. Your information will help guide the doctors toward an accurate diagnosis and treatment plan.

Your reserved appointment will take approximately an hour. You will meet one-on-one with the doctor who will perform a thorough examination and, if needed, x-rays. And, if appropriate, you may also receive some care on your first appointment.

Ruby Mountain Chiropractic Center offers a number of services specifically designed to enhance your life experience. Some of which include: chiropractic, rehabilitation, massage therapy, lifestyle medicine and nutrition. You have just taken your first step toward optimal health.

Please complete the following:

- **Health history** – information to understand your past and current health status.
- **Affordable care** – mesh your budget with the care you need.
- **Privacy protection** – your rights, records and disclosure.
- **Consent** – give the approval to begin the care that may greatly enhance your life.

Welcome to Ruby Mountain Chiropractic Center

LIFE. ELEVATED.

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Patient Information

First, M.I. and Last Name _____ **Date** _____

Date of Birth _____ **SS#** ___ - ___ - ____ **Gender** ◯Male ◯Female

Address _____ **City** _____

State _____ **Zip** _____ **E-mail** _____

Phone _____ **Occupation** _____

Who may we thank for referring you to us? _____

Height _____ **Weight** _____ Do you feel you are: ◯Underweight ◯Just right ◯Overweight

Have you unintentionally lost or gained 10 pounds or more in the last 3 months? ◯Yes ◯No

Reason for Office Visit

What is your primary pain/complaint? _____

Describe the quality of your primary pain/complaint? (select all that apply)

◯Sharp ◯Shooting ◯Dull ◯Ache ◯Crushing ◯Burning ◯Tearing ◯Tingling

Is there any pattern to the quality of your primary pain/complaint? (select all that apply)

◯Intermittent ◯Throbbing ◯Constant

On a scale of 0 to 10, with 10 being the greatest pain, how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10

When did you first notice your primary pain/complaint? _____

Did something cause your primary pain/complaint? _____

Are you married? ◯Yes ◯No If yes, please list your spouse's name _____

Do you have any children? ◯Yes ◯No If yes, please list their name(s) and age(s)

_____ _____

_____ _____

Did you see any other healthcare professionals? ◯Yes ◯No

If YES, what did they do for you? _____

What makes it better?

◯ Ice ◯ Rest ◯ Movement ◯ Other_____

What makes it worse?

◯ Sitting ◯ Standing ◯ Lying ◯ Other_____

What types of therapies have you tried for these problems or to improve your health overall:

- ◯ Diet modification
- ◯ Fasting
- ◯ Vitamins/minerals
- ◯ Herbs
- ◯ Chiropractic
- ◯ Acupuncture
- ◯ Conventional drugs
- ◯ Physical therapy
- ◯ Homeopathy
- ◯ Massage
- ◯ Other _____

Do you experience any of these general symptoms EVERY day?

- ◯ Debilitating fatigue
- ◯ Shortness of breath
- ◯ Insomnia
- ◯ Constipation
- ◯ Panic attacks
- ◯ Nausea
- ◯ Bleeding
- ◯ Depression
- ◯ Fecal incontinence
- ◯ Headaches
- ◯ Vomiting
- ◯ Itching/rash
- ◯ Urinary incontinence
- ◯ Discharge
- ◯ Dizziness
- ◯ Lost appetite
- ◯ Chronic pain/ inflammation
- ◯ Diarrhea
- ◯ Low grade fever

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Health History

Primary physician _____

Are you currently under care for any OTHER health conditions? _____

_____

Current medications (prescription or over-the-counter) _____

_____

Diagnostic procedures performed (blood and urine analysis, X-Rays, MRI, CT scan) _____

_____

Major hospitalizations, surgeries, injuries. List all procedures, complications (if any) and dates

YEAR SURGERY, ILLNESS, INJURY

_____ _____

_____ _____

_____ _____

_____ _____

On a scale of 0 to 10, with 0 being the lowest, how would you rate your current level of stress?

0 1 2 3 4 5 6 7 8 9 10

Identify the major cause of stress (chemical, physical, emotional ie: changes at work, finances, legal issues)

_____

BONE/JOINT

- ◯ Arthritis
- ◯ Gout
- ◯ Osteoporosis
- ◯ Other _____

GASTROINTESTINAL

- ◯ Colitis/Irritable Bowel
- ◯ Diverticulitis
- ◯ Gastroesophageal Reflex Disease (GERD)
- ◯ Gall Bladder Disorder
- ◯ Liver Disease
- ◯ Ulcer
- ◯ Other _____

HEART/LUNG

- ◯ Asthma
- ◯ Allergies/Hay Fever
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Pneumonia
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ Circulatory Problems
- ◯ Other _____

BLOOD

- ◯ High Cholesterol
- ◯ Diabetes
- ◯ Chronic Infection
- ◯ Other _____

NEUROLOGICAL

- ◯ Alzheimer's
- ◯ Depression
- ◯ Epilepsy
- ◯ Learning Disabilities
- ◯ Mental Illness
- ◯ Parkinson's
- ◯ Stroke
- ◯ Other _____

EYES, EARS, NOSE, THROAT

- ◯ Eyes, Ears, Nose, Throat Problems _____
- ◯ Glaucoma
- ◯ Sinus Infections

MEN

- ◯ Sexually Transmitted Disease (STD)
- ◯ Prostate Cancer
- ◯ Decreased Sex Drive
- ◯ Eating Disorder
- ◯ Infertility
- ◯ Alcoholism
- ◯ Autoimmune Disease
- ◯ Cancer, type _____
- ◯ Dental Problems
- ◯ Drug Addiction
- ◯ Other _____

WOMEN

- ◯ Sexually Transmitted Disease (STD)
- ◯ Menstrual Irregularity
- ◯ Decreased Sex Drive
- ◯ Infertility
- ◯ Fibrocystic Breast
- ◯ Fibroid Tumors
- ◯ Ovarian Cysts
- ◯ Vaginal Infections
- ◯ Pelvic Inflammatory Disease (PID)
- ◯ Pre-Menstral Syndrome (PMS)
- ◯ Eating Disorder

Date of last GYN Exam _____

Mammogram **+** **–**

PAP **+** **–**

Birth Control **Yes** **No**

Pregnancies _____

- ◯ C-Section
- ◯ Menopause
- ◯ Hysterectomy
- ◯ Alcoholism
- ◯ Autoimmune Disease
- ◯ Cancer, type _____
- ◯ Dental Problems
- ◯ Drug Addiction
- ◯ Other _____

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Health History

FAMILY HISTORY

(Parents/Siblings)

- ◯ Arthritis
- ◯ Asthma
- ◯ Alcoholism
- ◯ Alzheimer's
- ◯ Cancer, type _____
  _____
- ◯ Depression
- ◯ Diabetes
- ◯ Drug Addiction
- ◯ Eating Disorder
- ◯ Genetic Disorder
- ◯ Glaucoma
- ◯ Heart Disease
- ◯ Infertility
- ◯ Learning Disability
- ◯ Mental Illness
- ◯ Migraines
- ◯ Obesity
- ◯ Neurological Disorder
- ◯ Osteoporosis
- ◯ Stroke
- ◯ Other _____

HEALTH HABITS

- ◯ Tobacco
  Type _____
  Times per day _____
- ◯ Alcohol
  Drinks per week _____
  ◯ Wine ◯ Beer ◯ Liquor
- ◯ Caffeine
  Drinks per week _____
  ◯ Soda ◯ Coffee ◯ Tea
- ◯ Water
  Glasses per day _____

EXERCISE

Days per Week

- ◯ 1-2
- ◯ 3-4
- ◯ 5-7

Duration (minutes)

◯ < 30 ◯ 30 - 45 ◯ 60 +

Type

- ◯ Aerobic (Run/Jog/Bike/Swim)
- ◯ Stretch
- ◯ Weight Lift
- ◯ Walking

NUTRITION

- ◯ Meat and Vegetable
- ◯ Vegetarian/Vegan
- ◯ Restrictions _____

Eating habits, (meals per day)

_____

- ◯ Supplements
- ◯ Multi-vitamin
- ◯ Antioxidants
- ◯ Omega-3 (fish oils)
- ◯ Other _____

I WOULD LIKE TO:

Energy/Vitality

- ◯ Have more energy
- ◯ Sleep better
- ◯ Feel more rested
- ◯ Be pain free
- ◯ Reduce use of medications
- ◯ Improve sex drive

Body

- ◯ Lose weight
- ◯ Burn more body fat
- ◯ Improve muscle tone
- ◯ Increase strength
- ◯ Improve flexibility

Mental/Emotional

- ◯ Reduce stress
- ◯ Think more clearly
- ◯ Be more focused
- ◯ Improve memory
- ◯ Be less depressed
- ◯ Be less moody
- ◯ Feel motivated

Life Enrichment

- ◯ Reduce risk of degenerative diseases
- ◯ Slow aging
- ◯ Change from only treating pain/complaint to attempting to fix my problem or to get to as near normal as possible.

Affordable Care

1. If You Do Not Have Insurance: All payments are expected at the time of service or by a mutually agreeable payment plan. Your personal balance may not exceed $100 at any time or care may be suspended. There are affordable financial care plans offered, if interested please ask for additional information.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by a mutually agreeable payment plan. Your personal balance may not exceed $100 at any time or care may be suspended. There are affordable financial care plans offered, if interested please ask for additional information.

You are considered a cash patient until you bring your completed insurance information, and your insurance has been qualified and accepted. Assignment for secondary insurance carriers is not accepted. You will be provided with a claim form for your secondary carrier if requested.

Office fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

You will not be eligible for insurance assignment should your care be considered wellness care. Charges for services rendered will be due as they are rendered or by a mutually agreeable payment plan. Financial care plans make wellness care affordable, if interested, please ask for additional information.

If you discontinue care for any reason other than discharge by your provider, all balances will become immediately due and payable in full by you, regardless of any claims submitted or insurance status.

ANY OUTSTANDING BALANCE OVER 30 DAYS IS SUBJECT TO AN 18% PER ANNUM INTEREST RATE.

If a payment is returned by your bank or creditor unpaid for any reason, Ruby Mountain Chiropractic Center reserves the right to automatically withdraw that payment in-full by electronic funds transfer from that account or the credit account we have on file, along with an additional fee of $30.00.

PRINTED NAME _____

SIGNATURE _____

Your Privacy

Protecting your personal health information and privacy is important. This document describes how information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures by submitting the request in writing to Ruby Mountain Chiropractic Center.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer or medical records for treatment.

You may inspect and receive copies of your health records. These records will be provided to you within thirty (30) days of your request. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

A history of protected health information disclosure is accessible to you.

As your care progresses, you may periodically be contacted for your appointment reminders, announcements, electronic-mail (e-mail) newsletters, newsletters, text messaging and to inform you about Ruby Mountain Chiropractic Center and its team members.

Medicare and Medicaid Consent to Release Information (if applicable to you): By initiating or participating in care with Ruby Mountain Chiropractic Center you certify that the information given by you in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct and true. You further authorize any holder of medical or other information about you to release to the Social Security Administration, or its intermediary carriers, any information needed for your Medicare claim.

Ruby Mountain Chiropractic Center is required to abide by this notice. Ruby Mountain Chiropractic Center has the right to change this notice at any time, and any revisions will be prominently displayed in a clearly visible location within the office.

You may file a complaint about privacy violations by contacting the Director of Financial Services in writing that explains the context of the violation, and submitting it to:

Ruby Mountain Chiropractic Center
123 Second Street
Elko, NV 89801

or by contacting Ruby Mountain Chiropractic Center at 775.777.3033

The effective date of this Notice of Information Practices is January 1st, 2019.

Patient/Authorized Representative Initials _____ Date _____

Consent for Care

Consent for Care
I voluntarily consent to receiving and participating in my care that the doctor recommends for me, including all treatment and diagnostic procedures. I understand that I am under the care and supervision of an attending chiropractic physician in the state of Nevada and it is the responsibility of the Ruby Mountain Chiropractic Center team to carry-out their instructions. I further acknowledge that by initiating and participating in care with Ruby Mountain Chiropractic Center, I have been informed of and understand all of the risks (which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains), benefits, and reasonable alternatives to the care prescribed to and elected by me.

Consent for Minor
I consent to have my minor child receive and participate in care, including all treatment and diagnostic procedures, such as x-ray radiography. I understand that the care and supervision of care is provided by an attending chiropractic physician of Nevada, and it is the responsibility of the Ruby Mountain Chiropractic Center team to carry-out their instructions. I further acknowledge that by having my child initiate and participate in care with Ruby Mountain Chiropractic Center, I have been informed of and understand all of the risks (which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains), benefits, and reasonable alternatives to the care prescribed to and elected by me for my child.

Release of Information
You grant consent to Ruby Mountain Chiropractic Center team to use and disclose your protected health information for the purposes of treatment, payments, and healthcare operations. Our "your privacy" document provides detailed information about how we may use this information, and you agree that you have read and fully understand the practices and provisions noted within this document.

Results
My care with Ruby Mountain Chiropractic Center team involves clinical judgments and decisions made by both me and my provider(s). The decisions made by Ruby Mountain Chiropractic Center team are based on facts and information about me and are decisions given to provide care that is within my best interest toward an active healthy lifestyle. I understand that my decisions primarily influence my results, and just as with any health and wellness care, my results are neither guaranteed nor implied.

Pregnancy Notice (for women only, please check one)
I understand that it is important for my providers to know my pregnancy status. I also understand the "28 day rule" which defines that radiological examination, if so justified, can be carried throughout the cycle until a period is missed. If there is a missed period, a female should be considered pregnant unless proved otherwise. In such a situation, every care should be taken to explore other methods of getting needed information by using non-radiological examinations.

- ◯ To the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. Date of last menstrual period was _____
- ◯ I am currently pregnant, or suspect I am pregnant.

The signatures below confirm that the above document has been reviewed and fully understood. I sign this document without reservation, question, or concern.

Patient name (printed) _____

Patient or authorized signature _____ Date _____

Relationship to patient (if authorized signature) _____

Ruby Mountain Chiropractic Center witness signature _____