Health History

Patient: _____ **Date of Birth:** _____

Have you had any of the following:

Asthma ◯
Allergies ◯
Excessive Thirst ◯
Depression/Anxiety ◯
Diabetes ◯
Thyroid Condition ◯
Lupus ◯
Epilepsy ◯
HIV/AIDS ◯
General Fatigue ◯
Vertigo ◯
Dizziness ◯
Cancer ◯
Tumors ◯
High Blood Pressure ◯

Heart Attack ◯
Chest Pains ◯
Stroke ◯
Angina ◯
Kidney Stones ◯
Kidney Disorders ◯
Bladder Infection ◯
Loss of Bladder Control ◯
Prostate Problems ◯
Abnormal weight gain/loss ◯
Abdominal Pain ◯
Ulcers ◯
Hepatitis ◯
Liver/Gall Bladder Disorders ◯
Chronic Sinusitis ◯

Please list any other condition you have been diagnosed with.

_____

_____

_____

Women ONLY:
Pregnant: YES ◯

Take Birth Control: YES ◯

Implants/foreign objects in body: ◯ **NO** ◯ **YES : Explain** _____

Have you ever had any broken bones: ◯ **NO** ◯ **YES : Explain** _____

Have you ever had any spinal injuries: ◯ **NO** ◯ **YES : Explain** _____

Significant falls/accidents/injuries that required medical attention: : ◯ **NO** ◯ **YES : Explain** _____

_____

Have you ever had any surgeries: ◯ **NO** ◯ **YES : Explain** _____

_____

_____

Are you taking any medications: ◯ **NO** ◯ **YES: Please List** _____

_____

Are you taking any supplements: ◯ **NO** ◯ **YES : Please List** _____

_____

Family health history (parents, grandparents, sibling)

_____

Signature: _____ Date: _____

Sims Chiropractic Wellness Center P.C.
1190 Plett Rd Ste B, Cadillac MI 49601

Patient's Name: _____Date Of Birth_____

PRIVACY POLICY (HIPAA) We care about our patients' privacy, and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue a copy of this official notice of our privacy practices, whenever you request a copy. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

FEES
Spinal Adjustment: $38.00 Extremity Adjustment: $5.00 Established Patient Exam: $30.00 New Patient Exam: $50.00
Broken Appointment Fee: $30.00 -This includes missing appointments or not giving two hours notice when cancelling or rescheduling.
Chiropractic adjustment fees are based on the adjustment of the spine only. Fees are the same for all patients. Fees are posted. I understand that payment is due at the time of service, for all patients. This includes co-pays, co-insurance and deductible.

HEALTH INSURANCE PATIENTS I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign Sims Chiropractic Wellness Center PC to be directly conveyed any and/or all medical benefits, and/or insurance reimbursement otherwise payable to me, for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges, regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. The only billable insurances in our office are: A.S.R., B.C.B.S, BCBS Medicare, Medicare, Priority Health, and Priority Health Medicare- No exceptions. Any other insurance will be submitted by the patient. Our office will provide a super bill when requested. I understand that insurance only pays for medically necessary services.

INFORMED CONSENT *I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains.* I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure, which the Doctor feels at the time, based upon the facts then known, and are in my best interest. I have read or have had read to me, the above informed consent. I have also had an opportunity to ask questions about its content, with Dr. Sims and/or with other office staff. By signing below, I understand and have been informed of the possible risks of a chiropractic adjustment.
I intend this consent form to cover any and all treatments that are performed in this office. I understand that I will be informed of any other possible contraindications that may arise during treatment.
In order for Dr. Sims to know about any contraindications that may arise, I understand that I the patient, need to make Dr. Sims aware of any and all changes to my health, regardless of whether I believe it may have anything to do with why I am coming into Sims Chiropractic Wellness Center PC.

CONSENT I hereby request and consent to the performance of Chiropractic manipulation or adjustments, and other Chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays (not done in the office, but may be reviewed if brought in by myself, the patient), on me (or on the patient named below for whom I am legally responsible), by Dr. Sims. I have had the opportunity to discuss with Dr. Sims, and/or with other office or clinic personnel, the nature and purpose of Chiropractic manipulations, adjustments and other procedures. By signing below, I agree to the above named procedures.
I understand that chiropractic results are not guaranteed; every person reacts differently, and therefore may have different outcomes.

After reading the above informed consent and consent, do you need more explanation? Yes No

By signing below, I am acknowledging that I have read and understand each section above.
It is the responsibility of the patient to provide all medical updates since the previous visit.

(SIGNATURE) Patient (If Over 18) Or Parent/Legal Guardian Date