DR. BRAD DOUBLE
CHIROPRACTIC
"ADJUST TO WELLNESS"
1211 Warren Street • Jackson, Michigan 49203
Phone 517-990-0555 • Fax 517-990-0550

Assignment:

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to Big Vision, LLC for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of the assignment shall be considered as effective and valid as the original.

_____ _____
Patient Signature Date

Release of Information:

I authorize Dr. Brad Double Chiropractic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

_____ _____
Patient Signature Date

Financial Responsibility:

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Authorizing Care For Minor Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACITICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct the vertebral subluxations.

I _____ have read and fully understand
(PRINT NAME) the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(SIGNATURE)_____(DATE)_____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Dr. Brad Double Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Dr. Brad Double Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Brad Double Chiropractic.

The Notice of Privacy Practices for Dr. Brad Double Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Dr. Brad Double Chiropractic's duties with respect to my protected health information.

Dr. Brad Double Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by ask for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Dr. Brad Double Chiropractic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

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Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status: M S D W Date of Birth _____ Age_____

Social Security # _____

Occupation: _____

Emergency Contact:_____ Relation:_____ Phone# _____

How did you hear about us? (Circle One) Google Facebook Advertisement Location

Patient Ref erral: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. **Reasons for seeking chiropractic care:** _____

Primary reason: _____

Secondary reason: _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

3. **Past Health History:**

A. **Please indicate if you have a history of any of the following:**

☐ Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐ Bleeding problems

☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders
☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TI A's ☐ Other _____

☐ None of the above

B. **Previous Injury or Trauma:** _____

Have you ever broken any bones? Which?

_____

_____

C. **Allergies:** _____

D. **Medications:** _____

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

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Patient Name: _____ Date: _____

E. Surgeries:

Date Type of Surgery

_____

_____

_____

F. Females/ Pregnancies and outcomes:

I hereby state to the best of my knowledge, I am not pregnant,neither suspected or confirmed at this time. I do hereby release Dr. Brad Double,DC from any and all liability in this matter.
Patient Signature:_____ **Date:**_____

Pregnancies/Date of Delivery

_____

_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death:

_____

_____

_____

Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above
Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/ problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

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Patient Name: _____ Date: _____

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Brad Double, DC of Double Chiropractic for services performed.

Patient or Guardian Signature _____

Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name

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Symptom 1 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other: _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe):_____

Does the symptom radiate to another part of your body (circle one): yes no

- If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

- Did the symptom begin **suddenly** or **gradually**? (circle one)
- How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other: _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe):_____

Does the symptom radiate to another part of your body (circle one): yes no

- If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

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Symptom 3 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin? _____

- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):_____

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other: _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe):_____

Does the symptom radiate to another part of your body (circle one): yes no

- If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin? _____

- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? _____

What makes the symptom worse? (circle all that apply):

- Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

What makes the symptom better? (circle all that apply):

- Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other: _____

Describe the quality of the symptom (circle all that apply):

- Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe):_____

Does the symptom radiate to another part of your body (circle one): yes no

- If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

- Morning Afternoon Evening Night Unaffected by time of day