CHIROHEALTH

210 West Florence Blvd. • Casa Grande, AZ 85122 PO Box 10956 • Casa Grande, AZ 85230 (520)876-5500

WELCOME TO OUR OFFICE

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:_____ SOCIAL SECURITY #: _____ DATE:_____

DATE OF BIRTH:_____ AGE:___ SEX: M F MARITAL STATUS: M S D W # OF CHILDREN:___

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE #:_____ CELL PHONE #:_____

E-MAIL ADDRESS:_____ OCCUPATION:_____

COMPANY NAME:_____ LENGTH OF EMPLOYMENT:_____

TYPE OF WORK: OFFICE/CLERICAL LIGHT LABOR MODERATE LABOR HEAVY LABOR

SPOUSES NAME:_____

IN CASE OF EMERGENCY CONTACT NAME:_____ HOME PHONE #:_____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge.
I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:_____

INSURANCE COMPANY:_____ PHONE :_____

GROUP #:_____ ID :_____

Patient / Guardian Signature _____ Date_____

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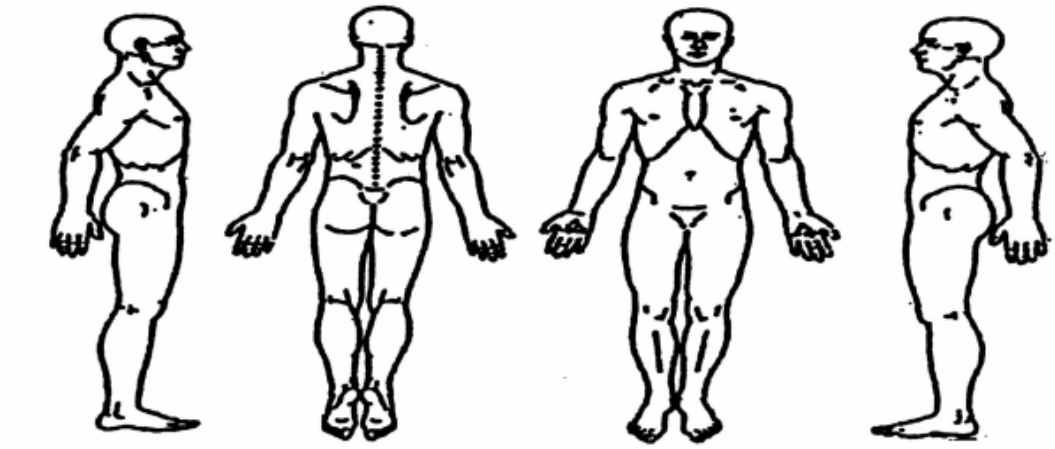
1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

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15. What is your: Height_____ Weight _____ Dominant Hand: Right or Left

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Hypertension
□ Heart Problems □ Cancer □ ALS □ Stroke

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?
□ Sit: □ Most of the day □ Half the day □ A little of the day
□ Stand: □ Most of the day □ Half the day □ A little of the day
□ Computer work: □ Most of the day □ Half the day □ A little of the day
□ On the phone: □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

RE: _____

DOB: _____

I hereby grant permission to ChiroHealth LLC to release or obtain any medical records needed to evaluate my condition or treatment.

Mail to:

ChiroHealth LLC
PO BOX 10956
CASA GRANDE, AZ 85230
FAX: 480-393-4613

I also authorize ChiroHealth LLC to release medical records, and /or medical bills, for services rendered to any insurance company, whether pursuant to medical payments coverage, health insurance or liability coverage, as long as I have an outstanding balance with them. I further authorize any insurance company to provide insurance and status information to ChiroHealth LLC.

I understand that I may revoke this authorization at any time providing I notify ChiroHealth LLC in writing. This authorization is valid for three years from the date it is signed by me.

Patient's Signature: _____

Date: _____

IF A MINOR – SIGNATURE OF PARENT OR LEGAL GUARDIAN REQUIRED BELOW:

Signed: _____ For: _____

(Signature of Parent or Guardian) (Patient's Name)

A photocopy of this original is to be treated as an original.

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Send information to the address listed above.

DISCLOSURE OF FEES/PAYMENT POLICY

99201	New Patient Evaluation and Management	$ 79.00
99202	New Patient Evaluation and Management	$ 95.00
99203	NP-Detailed History and Examination	$125.00
99211	Established Patient Office Visit	$ 40.00
99212	Established Patient Office Visit	$ 70.00
99213	Est Pt-Expanded History and Examination	$ 75.00
98940	Chiropractic Spinal Manipulation 1-2 Regions	$ 40.00
98941	Chiropractic Spinal Manipulation 3-4 Regions	$ 50.00
97140	Manual Therapy	$ 39.00
97010	Hot and Cold Packs	$ 25.00
97012	Mechanical Traction	$ 29.00
97014	Electrical Stim.	$ 29.00
97035	Ultrasound	$ 33.00
97530	Therapeutic Activities - per unit	$ 48.00
97110	Therapeutic Procedure - per unit	$ 50.00
97112	Neuromuscular Reeducation - per unit	$ 50.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check is returned for insufficient funds, I will be charged a $25.00 service charge.

I further understand that if my insurance company declines payment, I authorize ChiroHealth LLC to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed_____ Date_____

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Informed Consent to Chiropractic Treatment

The Nature of the Chiropractic Adjustment

We will use our hands or a mechanical device upon your body in such a way to move your joints. That may cause an audible. "pop" or "click," much as you have experienced when you crack your knuckles. You may feel or sense movement.

The Material Risks Inherent in Chiropractic Adjustment

As with any health care procedures, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injures, dislocations, muscle strain, cervical myelopathy and costovertebral strain and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone or bone disease, which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such and outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

The Availability and Nature of Other treatment Options

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain relievers
- Hospitalization with traction
- Surgery

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Included:

Overuse of the over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patent's general health, severity of the patient's discomfort, his/her pain tolerate, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain relieves can produce undesirable side **effects and patients dependence**. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/ her pain tolerance, and self-discipline in not abusing the medicine, and proper professional supervision. Such medications generally very significant risks—some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor injured) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain, and exposure to communicable disease is likely with adverse result from such expose dependent upon unknown variables.

The risk inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalizations and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. In addition, compromise to your neurophysiological integrity and health of your nervous system will continue. Over time, these processes may complicate treatment, making the treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT Sign Until You Have Read and Understand The Above.

Please check the appropriate block and sign below:

I have read [ ] or **have had read to me [ ]** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to CHIROHEALTH LLC and Nephi Riordan, D.C. to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

_____ _____

Date Patient Printed Name

_____ _____

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LETTER OF NO ACCIDENT OR WORK INJURY

_____

Patient Name

Dear Insurance Company,

This letter is to inform you that I was not involved in any Auto or work injury for this diagnostic test and / or treatment.

Please note the following:

_____ I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my treatment is not the result of an injury while on the job or by any other person related to my employment.

Please process my claim properly with no delay!!

Sincerely,

_____

Patient's Signature

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

ChiroHealth LLC
PO Box 10956
Casa Grande, AZ 85130

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

See Above Address

for the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated at this _____ day of _____ 20__.

_____ _____
Signature of policyholder Signature of Claimant, if other than Policyholder

_____
*With my signature above, the full deductible or co-payment would be a financial hardship on me.