Date: _____ Patient #: _____

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Name:_____ Social Security #:_____ Home Phone:_____

Address:_____City:_____State:_____Zipcode:_____

Email
Address:_____Cellphone:_____

Best Point of Contact: ____Home ____Cell ____Email

Date of birth_____ ____Male ____Female Race:_____ Marital Status: M S W D

Occupation:_____Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse/Guardian (Circle one):_____Phone:_____

Date of
Birth:_____Employer:_____

Contact person in case of an emergency: _____Phone:_____

To whom, other than yourself, may we speak with regarding your account/care?_____

If minor, who may we speak to regarding their care?_____

How were you referred to our office?_____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care this office? _____ Medical Doctor:_____
Address:_____Phone:_____

PAYMENT FOR SERVICES RENDERED

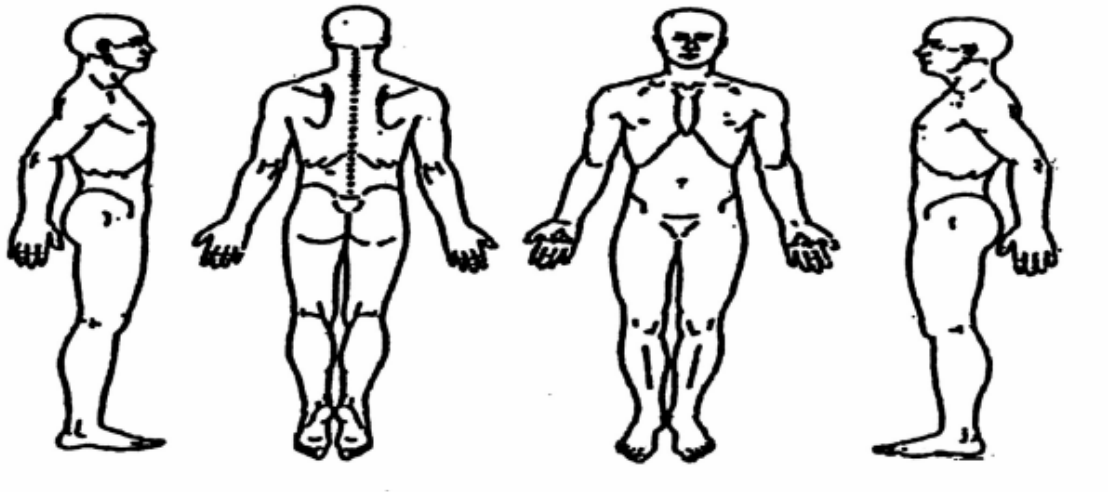
As a courtesy to our patients, Partners in Health & Wellness will file your claim in an attempt to obtain payment from insurance carriers or any other responsible parties. We will make our best effort to secure payment directly from them on your behalf. However, if we do not have a resolution within 90 days, we reserve the right to secure payment from you. Be sure to check with your insurance company prior to the 90-day time frame to resolve any issues that may arise. We do, however, expect payment at the time of service that is due by you (copay, co-insurance, deductible, etc.) whether you have insurance or not.

I understand that in the event that no health insurance coverage exists, payment arrangements may be made with Partners in Health & Wellness. I, _____, authorize Partners in Health & Wellness to debit the credit card listed below in my absence for payment (copayment, coinsurance, and deductible) due.
Credit Card #:_____Expiration Date:_____ CVV:_____
Authorized
Signature:_____Witness:_____

Patient Intake Form

Patient Name:_____ Date:_____

1. Is today's problem caused by:__Major Medical ___Auto Accident ____Worker's Compensation
2. Where is your pain located? 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. What caused your problem?_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13**.** What aggravates your problem?_____

14. What alleviates your pain? _____

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

16. What is your: Height_____ Weight _____

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

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

19. Do you drink alcoholic beverages? _____ If yes, how many per week? _____

20. Do you use any tobacco products? _____ If yes, how much per day? _____

21. Do you consume caffeine? ____ If yes, how much per day? _____

22. What are your hobbies? _____

23.Check if applicable & indicate whether family member is **F**ather, **M**other, **S**ister, or **B**rother :

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Disease	□ Cancer	□ ALS
□ Tuberculosis	□ Stroke	□ Asthma
□ Kidney Disease	□ Liver Disease	□ Lung Disease

Father: ___living ___deceased Current age if still living:___
Cause of death & age at death, if deceased:_____

Mother: ___living ___deceased Current age if still living:___
Cause of death & age at death, if deceased:_____

Check if applicable to you: _____ As an adopted child, little is known about birth parents or family.

Do you have any family members who suffer from the same condition as you? If so, please list:_____

24. For each 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 Dependence
□	□ 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		**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		
□	□ Flu Shot	□	□ Other: _____		

25. List all prescription medications you are currently taking:

_____

Medication Allergies: _____

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

_____

27. List all surgical procedures you have had: _____

28. 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

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

30. Have you ever been hospitalized**?** _____ If yes, why? _____

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

32. Anything else pertinent to your visit today?_____

Patient's Signature_____ **Date:**_____

Doctor's Signature_____**Date:**_____

OFFICE POLICIES

Payment for copays and cash visits are due at the time service rendered unless prior arrangements are made. All non-covered services, such as deductibles and co-insurance will be billed and is due and payable once the insurance company has settled. These services will be described before treatment is rendered. If your insurance company denies a claim, realize that we will do our best to get the claim paid; however, it is ultimately your responsibility to follow up with your insurance company and pay the balance if it is denied.

If your insurance company requires a primary care referral, it is your responsibility to obtain such prior to services being rendered or the insurance company may deny your claim.

Some insurance companies require specific paperwork for authorization of treatment. These forms must be completed prior to services being rendered or the insurance company may deny your claim. We will submit the forms to the insurance company for you for approval and let you know your coverage.

Balances that are unsettled after 60 days may incur interest of 2.5%. This fee will be collected at the time of settlement Accounts over 90 days without prior financial arrangements with Partners in Health & Wellness may be considered for referral to an outside agency for collection and will incur a $50.00 processing fee.

A $45.00 returned check fee will be assessed for non-sufficient fund returned items.

It is customary that our patients schedule appointments prior to coming in for treatment. Walk-in and call-in patients will be seen on a work-in basis. Patients with pre-scheduled appointments will be seen first.

Patients who have no show/no call missed appointments will be will charged a $35.00. Appointments not cancelled 24 hours prior will also be assessed a $35 fee as well. We realize that emergencies arise that may prevent you from keeping your appointment. Please call as soon as possible. Please leave a message on our confidential voicemail cancelling your appointment if we are not available to take your call.

Microsoft Health Vault Opt Out: I understand that my chiropractor has the ability to provide me with electronic health records via Microsoft Health Vault. I have chosen not to participate in this program. _____ Agree _____Disagree

I have read and understand the above statements. I agree to adhere to the office policies of Partners in Health & Wellness.

Patient/Responsible Party:_____ Date:_____

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we always have and always will respect the privacy of your health information. There are several circumstances which we may have to use or disclose your information:

- To another healthcare provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- To another party if they are potentially responsible for payment of your services.
- Within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices. In the event of changes, we will notify you by mail or when you come in for treatment.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction agreement is binding.

YOUR RIGHT TO REVOKE AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to Charles Hecht, DC/Partners in Health & Wellness. I authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers to secure the payment of benefits. I understand that I am ultimately responsible for all costs of chiropractic care regardless of health insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by Dr. Hecht, any fees for services will be immediately due and payable.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some inherent risks associated with treatment, including but not limited to fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Furthermore, I wish to rely on the doctor to exercise his judgment during the course of the procedure which the doctor feels, at the time, based upon the then known facts, are in my best interests.

I have read and understand the above consent form and agree to the above terms.

Signature of Patient/Guardian _____Date_____