CONFIDENTIAL PATIENT INFORMATION
ADVANCED CHIROPRACTIC AND WELLNESS CENTER

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly, read, and sign all documentation.
Feel free to ask any questions concerning your paperwork.

Today's Date: _____ **Have you consulted a chiropractor before?** _____

Whom may we thank for referring you? _____

Date of Birth: _____ **Gender:** _____

Social Security Number: _____

Age: _____ **Height:** _____ **Weight:** _____

Full Name: _____

Address: _____

City/State/Zip: _____

Cell Phone: _____ **Other Phone:** _____

Email: _____

Emergency Contact Name/Number: _____

Marital Status: Single _____ **Divorced** _____ **Married** _____ **Widowed** _____

Your Occupation: _____

Your Employer: _____

Employer Address: _____

Type of Case: _____**CASH** _____**Personal Insurance** _____**Worker's Comp** _____**Auto Accident**

_____**Medicare**_____**Other: explain** _____

Primary Care Provider's Name: _____

Insurance Carrier: _____

Name of Insured: _____

Date of Birth of Insured: _____

Who carries this policy? _____**Self** _____**Spouse** _____**Parent**

Policy Number: _____

Insured's Employer: _____

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ABOUT YOUR CURRENT CONDITION

Date condition began: _____ Pain Level (1-10) _____

Please describe your symptoms: _____

_____

_____

Is this condition getting worse or is it chronic or comes and goes? _____

What activities make the pain worse? _____

_____

What activities make the pain better? _____

_____

Does this condition interfere with: _____ Work _____Sleep _____Daily Routine

Explain: _____

Have you had this condition in the past? _____

List all medications you are taking: _____

_____ _____

_____ _____

List any Medical Conditions you have: _____

_____ _____

List ANY allergies: _____

Previous Surgeries: _____

_____ _____

Previous Accidents: _____

Are you Pregnant? If so, how far along are you? _____

PROVIDER/CLINIC NAME_____

DATE OF VISIT ___/___/20___ Patient_____ DOB_____

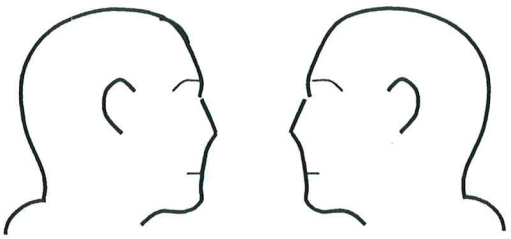
Check All that Apply: _____NEW PATIENT _____ RE-EVALUATION _____ NEW CONDITION _____ ROUTINE VISIT

FOR INITIAL EXAM OR NEW CONDITION, Please give first date you noticed symptoms _____

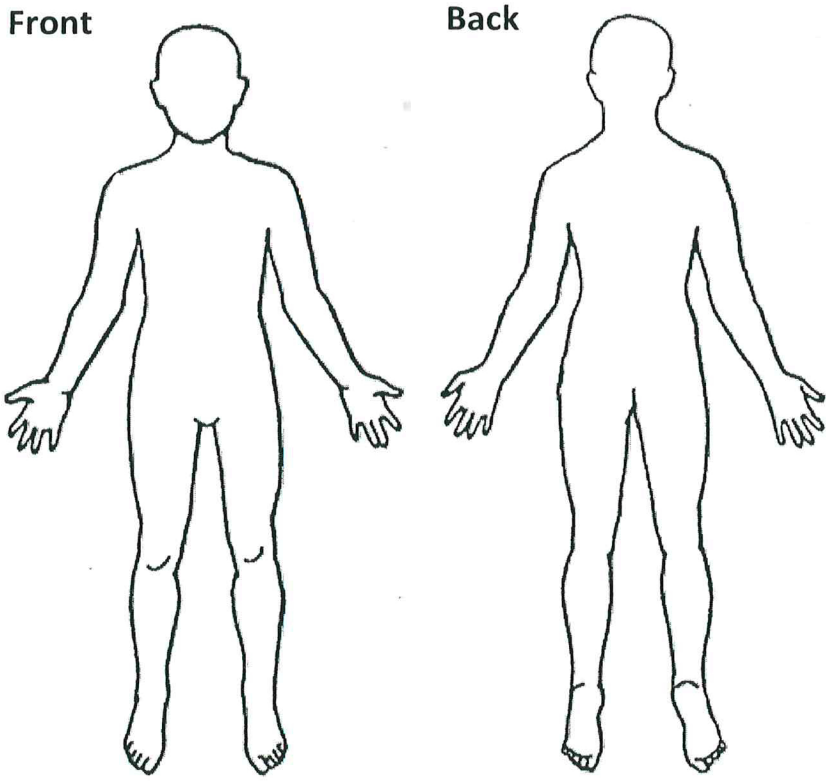
FOR INITIAL EXAM OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

PATIENT/LEGAL GUARDIAN SIGNATURE_____

Doctor/Provider Signature

NEUROPATHY EVALUATION

Patient Name: _____

1. Which symptoms apply to you?

- □ Numbness
- □ Tingling
- □ Aching
- □ Radiating into legs/feet
- □ Radiating into arms/hands
- □ Difficulty grasping with hands
- □ Neck or low back pain
- □ Spinal Stiffness
- □ Difficulty walking
- □ Grip weakness
- □ Lack of Balance

2. Do any of these conditions apply to you?

- □ Diabetes
- □ Environmental Toxicity such Lead or Mercury
- □ Post chemotherapy
- □ Shingles
- □ Peripheral Vascular Disease
- □ Restless leg syndrome

3. How long have you experienced neuropathy symptoms?

_____

4. Have you been treated medically?

□ Yes □ No

5. Was the treatment helpful?

□ Yes □ No

6. Do you have a defibrillator?

□ Yes □ No

PACEMAKERS QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

1. Please list date when the pacemaker was implanted: _____
2. The pacemaker was implanted for: ☐ Heart block associated with coronary artery disease ☐ Complete heart block or sick sinus syndrome ☐ Chronic underlying atrial flutter/fibrillation ☐ Other, please give details.
3. Do you have a defibrillator?
4. Do you have any other kind of heart condition?

Patient signature: _____ Date: _____

Advanced Chiropractic Center and Wellness

Massage Therapy

Policies and Procedures

It is our intention too provide our patients with professional and therapeutic services. The following policies and procedures serve as a guide for first-time and repeat clients.

Arrival to Your Massage:

Please arrive for your appointment 15 minutes prior to the scheduled starting time. All massages have a specific time schedule and early arrival allows for a relaxed and unhurried experience. If late arrival is inevitable, your services may be shortened to keep on schedule. The original treatment time will be charged.

Cancellation Policy:

Please provide at least 24-hour notice if you need to reschedule or cancel a treatment. If a client fails to cancel within 24-hours multiple times (2 or more), they may be asked to prepay for future services or will lose standing appointments. For all appointments missed or canceled within the 24-hour period, a $25.00 fee will be charged each time.

Late Arrival Policy:

We regret that late arrivals may not receive extension of scheduled appointments. In special cases, and when our schedule will allow, we may be able to accommodate a partial or full appointment. The original reservation fee will be charged.

No Show Policy:

We understand that unanticipated events occur in everyone's life. Unforeseen events such as car problems, business meetings, and children's illnesses are just a few reasons why one may consider cancelling a massage appointment. However, we ask that you call as soon as possible if you cannot keep your appointment. Clients who fail to show for appointments may be asked to prepay for future services and will be charged $25.00. It is important that our massage therapists are compensated for reserved slot times.

Scope of Practice:

Our therapists are licensed professionals and held to the highest standards of the American Massage Therapy Association.

Respect for Client Needs and Boundaries:

Our massage therapists are happy to adjust pressure, temperature, musical volume, or work longer on an area or move on if you request it.

The client may choose to: leave on as much clothing as needed for comfort, refuse any massage methods or stop the massage at any time.

The client will always be modestly draped. The only area being massaged will be undraped. Sexual interaction or discussion of any kind between the client and the massage therapist is NEVER appropriate.

Existing or New Medical Conditions:

It is the responsibility of the client to keep the massage therapist informed of any medical conditions currently being treated. The client must also keep the massage therapist informed of any changes in health conditions. Also, please inform your therapist of any wounds such as bruises, varicose veins, cuts, or any skin conditions that are contagious.

Our Philosophy

It takes both the therapist and client working to create a positive effect on the outcome the client wishes to achieve. This is the whole concept behind Advanced Chiropractic, therapist and client.... Each doing their part to create change.

I have read the above statements and agree to these policies and procedures.

Patients Signature: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Signature of Patient Date

Patient Name:_____ Patient #: _____

PAYMENT POLICY INFORMATION

Payment for Services will be by: Cash____ Check_____ Credit Card_____

Chiropractic Services provided in this office are payable the day services are rendered unless other arrangements have been made prior to seeing the doctor.

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.

2. There will be a $5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2(two) insurances are involved.

3. Payment Plan is available upon approval of credit extension by the Office Manager. I authorize a credit check if credit is extended.

4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage, however **"benefits quoted are not a guarantee of payment"**. Benefits are determined at the time of processing.

5. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.

6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY:

PATIENT'S SIGNATURE: X_____ Date:_____
(OR GUARDIAN / GUARANTOR)

Witness's Signature:_____ Date:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Doctor Name: Ren Halverson, D.C. P.C.

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

Advanced Chiropractic Center

HARDSHIP ADVISORY

I have assigned payments from my insurance company to go directly to Advanced Chiropractic Center, I have been advised that it is the policy of this office to collect directly from me all amounts not paid by the insurance company, including deductibles and or co-payments.

This letter affirms that it would be a hardship for me to pay these amounts, and if required I would not be able to receive necessary treatment at this time.

I do agree to pay _____ deductible and _____co-payment.

_____ _____

Patient Signature Patient Name

_____ _____

Witness Date

Advanced Chiropractic/Wellness Center

912-262-9735 Fax 912-262-9634

CELL PHONE POLICY

Our responsibility to our patients is to do everything we can to help you recover quickly and remain healthy in the future. To do that, we have to have excellent communication between our patients, the doctors and our staff. To help us with that, we ask you turn off your cell phones while being treated. We need to have patients' full attention to communicate effectively. Thanks for helping us help you get well.

Advanced Chiropractic Center Staff

What's in a number?

How to rate your symptoms, 1 - 10

10 - Your pain is intense, constant, greatly restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain.

9 - Same as above, but you can forget about the pain up to 15 minutes at a time.

8 - The pain is significant, moderately intense at times, but not constant. Most activities are affected, you think about it once or twice an hour.

7 - Same as above, except that the pain is never intense.

6 - The pain is moderate yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.

5 - Same as above, except that almost no activities are affected.

4 - The pain is little more than a nuisance, and you go through the whole day frequently aware, but never affected by it.

3 - Same as above, except that the awareness of the pain may be absent for a whole day at a time.

2 - At its worst, the pain is best described as "a little uncomfortable". Days can go by without being aware of it.

1 - Same as above, except that the symptom does not recur more frequently than once a week.