CHIROPRACTIC DEL SOL

325 W McDowell Rd Phoenix, Az 85003

CONFIDENTIAL PATIENT REGISTRATION FORM

Name:_____ Social Security Number:_____-_____-_____

Date of Birth: Month:_____Day:_____Year:_____ Age:_____ Driver's License Number:_____

Address: _____ _____ _____ _____ _____
Street Apt # City State Zip Code

Telephone Number: (_____) _____-_____ (____)_____-_____ E-Mail:_____
Home Cell

Profession:_____ Name of Employer:_____

Work Address: _____ _____ _____ _____ _____
Street Suite# City State Zip Code

Sex: (M) (F) Marital Status:(S) (M) (D) (W) Spouse's Name:_____#of Children:_____

Referred by?: (Doctor) (Attorney) (Friend/Family) (Walk-in) (Other_____)

Did you find our office online? Yes____No_____ (Google) (Facebook) (Yelp) (Other_____)

Previous Chiropractic Care? Yes____No_____ Previous Physical Therapy? Yes____No_____

Is your Office visit the result of: Auto Accident_____ Work Injury_____ Sports Injury _____ Other _____

May we send appointment reminders by Text? Yes____No_____ May we contact you by E-Mail? Yes____No_____

Primary Insurance:_____ Named Insured:_____

Policy Number: _____ Group Number:_____

Secondary Insurance:_____ Named Insured:_____

Policy Number: _____ Group Number:_____

Name of Attorney:_____ Phone(_____)_____-_____

Auto or Work Injury Claim Number:_____

Please explain the reason for your visit today: _____

Date symptoms began? _____ Have you seen a Doctor(s)? Yes____No_____ Name(s):_____

List previous accidents/injuries: _____

List all surgeries: _____

Previous Hospitalization? Yes____No_____ Reason?_____ Number day(s)Admitted?_____

List of Medication(s) or Vitamin(s):_____

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MEDICAL HISTORY

Are you possibly pregnant? Yes____No_____ **If yes,** how far along? _____

Date of last menstrual period:_____ Have you had a hysterectomy? Yes____No_____

Please explain any current health conditions: _____

_____

_____

HEART	Yes____No_____	KIDNEYS	Yes____No_____
GALLBLADDER	Yes____No_____	THYROID	Yes____No_____
LIVER	Yes____No_____	ALLERGIES	Yes____No_____
ULCERS	Yes____No_____	OTHER	Yes____No_____

Please check any of the following that apply to you:

PAST	PRESENT		PAST	PRESENT	
___	___	History of recent Infection	___	___	Prostate Issues
___	___	Fever	___	___	Frequent Urination
___	___	HIV/AIDS	___	___	Pregnancy, Number of Births_____
___	___	Diabetes	___	___	Abnormal Weight: ___Loss ___ Gain
___	___	Corticosteriod Use	___	___	Epilepsy Seizures
___	___	Birth Control Pills	___	___	Visual Disturbances
___	___	High Blood Pressure	___	___	Back Pain
___	___	Neck Pain	___	___	Arthritis
___	___	Dizziness/Fainting	___	___	Alcohol Use
___	___	Numbness in Groin	___	___	Numbness around Buttocks
___	___	Urinary Retention	___	___	Tobacco Use
___	___	Aortic Aneurysm	___	___	Physical Trauma
___	___	Cancer/Tumor	___	___	Osteoporosis
___	___	Heart Attack -Date:_____	___	___	Stroke-Date:_____

Family History: ___Cancer ____Diabetes ____High Blood Pressure ____Cardiovascular Problems/Stroke

Number of Soda per day: _____ Number of Coffee per day: _____

How many days per week do you normally exercise or stretch? _____

Please provide a brief description of your accident or injury: (if applicable)

_____

_____

_____

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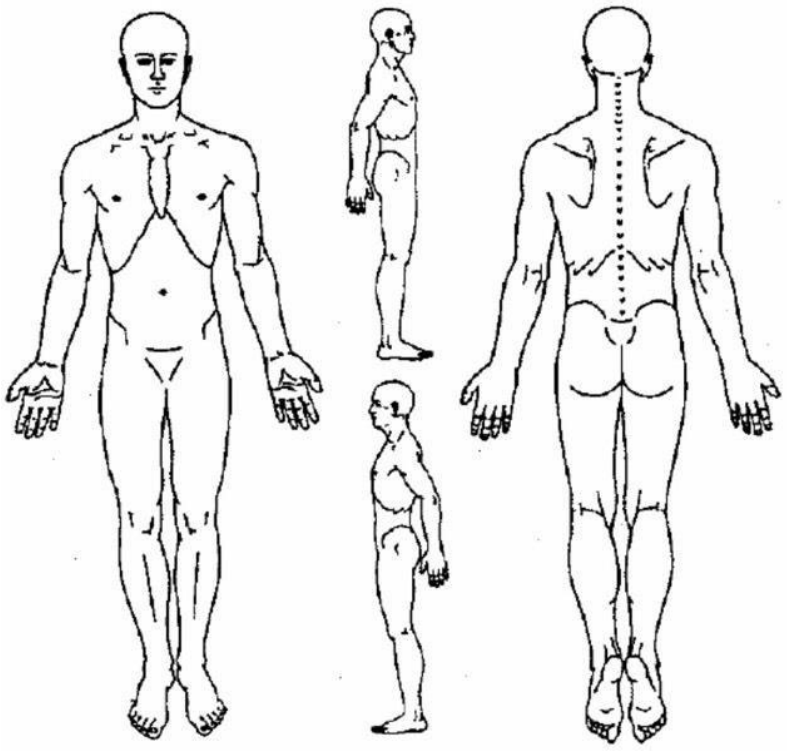
PAIN DIAGRAM

Draw the location of your pain on the figures below using the following symbols:

Ache	Numbness	Pins & Needles	Burning	Stabbing	Other
^^^^^	OOOOO	*****	=====	/////	XXXXX

Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10



X _____ **X** _____

SIGNATURE DATE

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FINANCIAL POLICY

Thank you for choosing our office for your health care. We are committed to providing the highest quality service. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to your treatment. You are expected to pay all charges in full at the time of service if:

You have no medical health insurance coverage
You prefer to file your own insurance
Your insurance carrier sends payments directly to you
Insurance benefits cannot be verified by our office
Proper authorization from your insurance carrier has not been received

In the event billings from this office are not paid within our normal credit terms, a fee of 1 ½ % per month, 18% per annum shall accrue until paid. In addition, all reasonable collection and attorney fees will be charged to the patient.

We accept Cash, Checks, Debit, Visa and MasterCard. A charge of $25.00 will be imposed for all returned checks.

REGARDING INSURANCE

Our office files primary insurance as a courtesy for all of our patients. Please bring your insurance card and a claim form with you to keep our office informed of all insurance changes and special authorization request. We cannot bill your insurance company unless you bring in all the insurance information. We may accept payment of a portion of your bill from health insurance benefits. We will obtain a pre-estimate of benefits upon your request. However, we require the uninsured portion of your bill to be paid by the time treatment is completed. The balance of the fee, after deducting any payment received from the insurance company, shall be the sole responsibility of the patient. If payment has not been received from any billing to an insurance company within 60 days of treatment completion, the unpaid balance will immediately become due and payable by the patient who then may pursue the insurance company for reimbursement.

Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Please be aware that some or all of the series rendered may not be covered by your insurance plan.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best health treatment for our patients, and we charge within the range of what is Usual and Customary for such health treatment in our area. The "Usual and Customary Rates" that insurance companies use to determine their benefits are decided upon by them based upon factors not within our control. You are responsible for payment of the fee charged regardless of any insurance company's fee schedule.

CANCELLATION AND MISSED APPOINTMENT POLICY

Please provide a 24-hour notice for cancellation of your chiropractic appointment. In the event of a missed appointment (no call/no show), prepayment will be needed to schedule your next visit. Two missed appointments (no call/no show) may result in dismissal from the practice.

Please help us serve you better by keeping scheduled appointments. We will assist you by providing a reminder of your appointments. Thank you for your review and consideration of our Financial Policy. Please let us know if you have any questions**. I have read this Financial Policy and agree to abide by the terms:**

X _____ **X** _____

SIGNATURE DATE

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INFORMED CONSENT FOR TREATMENT

The Nature of chiropractic treatment: A chiropractic therapeutic maneuver that utilizes controlled force, leverage, direction, amplitude, and velocity and which is directed at specific joints of anatomical regions. Chiropractors commonly use such procedures to influence joint and neurophysiologic function. The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral disc, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. Certain ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare". The risk of cerebrovascular injury or stroke has been estimated at between one in one million to one in twenty million, and it can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics: The risks of taking these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Prescribed medications: The risks of taking ant-inflammatory drugs, tranquilizers, and analgesics include a multitude of undesirable side effects and patient dependence in a significant number or cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment can result in the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult and prolonged.

I understand that a chiropractor in the Clinic will answer any questions that I have to the best of his/her ability. I understand that results are not guaranteed. I do not expect the Clinic chiropractors to be able to anticipate and explain all risk and complications. I will rely on my chiropractor to exercise his/her judgment during the course of procedures which he/she may feel are in my best interest. With this knowledge, I voluntarily consent to diagnostic tests and chiropractic care recommended by my chiropractor for: (please list exceptions below):

_____

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient of this Clinic is not intended to restrict me from receiving treatment or advice that I may now be receiving, or may in the future receive, from another licensed health care provider;
- I am at liberty to seek or continue chiropractic care from a chiropractic physician or other health care provider qualified to practice in Arizona;
- No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed healthcare provider;
- This Consent Treatment Form has been explained to me, and I fully understand and agree to its content.
- I have read and understood the explanation above regarding chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction.
- I have fully evaluated the risks and benefits of undergoing treatment.
- I have freely decided to undergo recommended treatment and hereby give my full consent of treatment at Chiropractic Del Sol LLC.

X _____ **X** _____

PATIENT'S SIGNATURE DATE

If the patient is a minor or is unable to consent, please complete the following:

1. Patient is a minor and is _____ years of age. Name of Father: _____ Name of Mother: _____
2. Patient is unable to Consent to Treatment because: _____

X _____ **X** _____ **X** _____ **X** _____

SIGNATURE OF RELATIVE OR LEGAL GUARDIAN RELATIONSHIP WITNESS OF SIGNATURE DATE

- Patient is able to understand the language and meaning of this document as printed: Yes ____ No_____
- Patient is mentally oriented as to current time, today's date, and physical location: Yes ____ No_____

X _____ **X** _____ **X** _____

DATE TIME DOCTOR'S SIGNATURE

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HIPAA

(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is being used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

The patient understands the following:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

X _____ **X** _____

PRINTED NAME SIGNATURE

X _____

DATE

IF NOT THE PATIENT:

X _____ **X** _____

REPRESENTATIVE'S SIGNATURE RELATIONSHIP TO THE PATIENT

X _____

DATE

Witness: **X** _____ **X** _____

PRINTED NAME, PRACTICE REPRESENTATIVE SIGNATURE, PRACTICE REPRESENTATIVE

X _____ DATE