Active Chiropractic Spine & Joint Center, LLC

Confidential Patient Health Record

Date:_____/_____/_____

Name:_____ Social Security #:_____
Home Phone:_____ Cell Phone:_____
Address:_____
City:_____ State:_____ Zip:_____
E-mail Address:_____ Fax #_____
Age:_____ Birth Date:_____ Gender: Male____ Female____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____
Employer's Address:_____ Office Phone:_____
Spouse:_____ Occupation:_____ Employer:_____
How Many Children?_____ Ages of Children:_____

Emergency Contact:_____ Phone:_____
Relationship to You:_____

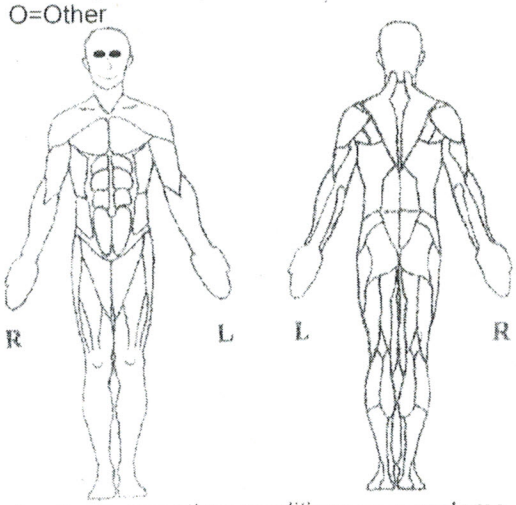
How were you referred to our office?_____

Family Medical Doctor:_____ Phone:_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

HISTORY OF PRESENT ILLNESS:

Chief Complaint (Why are you here):_____
_____
Date symptoms appeared: _____/_____/_____
Is this due to: Auto Work Other_____
Have you had this condition in the past? Yes No
If yes, when and describe:_____
_____
Days lost from work:_____
Date of last physical exam:_____
How frequent is the condition?
Constant Frequent Intermittent
Occasional Night Only
How long does it last? All Day Hours Minutes
Describe the pain:
Sharp Aching Numbness Dull
Tingling Burning Stabbing
Other_____
Is there anything you can do to relieve the problem?
Yes No If yes, describe:_____
_____
If no, what have you tried that has not helped?_____
_____
What makes the problem worse?
Standing Sitting Lying Bending
Lifting Twisting Other_____
_____
Have you seen other doctors for this condition?
Yes No Type of treatment:_____
If yes, Who? (name)_____
Were you satisfied with your treatment? Yes No

Use the letters below to indicate the type and the location of your pain or problem:
A=Ache B=Burning N=Numbness
S=Sharp T=Tingling P=Pins and Needles
O=Other



Are there any other conditions or symptoms that may be related to your problem?
Yes No
If yes, describe:_____
_____
Are there other unrelated health problems?
Yes No
If yes, describe:_____
_____

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain
Date of last Menses ____/____/____ My menses is Regular Irregular
Are you currently taking an oral contraceptive (birth control pill)? Yes No

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from any of the following? (Place a check mark by conditions that apply to you.)

Broken or Fractured Bones
Osteoarthritis
Strokes
Cancer
Eating Disorder
Ulcers
Circulatory Problems
Epilepsy
Alcoholism
Coughing Blood
Pace Maker
Drug Addiction
High/Low Blood Pressure
Seizures/Convulsions
HIV Positive

Excessive Bleeding
A Congenital Disease
Gall Bladder
Ruptures
Depression
Diabetes
Tuberculosis
Asthma
Kidney Disease
Kidney Stones
Liver Disease
Mental Illness
Heart Disease
Lung Disease
Rheumatoid Arthritis

Chills
Unintentional Weight Loss
Fever
Night Sweats
Blurred Vision
Dizziness
Headaches
Slurred Speech
Numbness
Facial Weakness
Limb Weakness
TMJ Problems
Abdominal Pain
Blood Clots

Please explain any checked conditions:_____

Do you have a history of stroke or hypertension? Yes No
Have you had any major illness, hospitalization, injury, fall, auto accident or surgery? Yes No
If yes, explain:_____

Women, please include information about childbirth (include dates): _____
Have you been treated for any health condition by a physician in the last year? Yes No
If yes, explain:_____
What medications or drugs are you taking?_____
Do you have any allergies to any medications, nutritional products or food? Yes No
If yes, describe:_____
Do you have any allergies of any kind? Yes No
If yes, describe:_____
Please list any other health problems you have, no matter how insignificant they may be:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week?_____
Do you use any tobacco products? Yes No If yes, what kind:_____
Do you smoke? Yes No If yes, packs per day:_____
Do you take vitamin supplements? Yes No If yes, please list:_____
Do you consume caffeine? Yes No If yes, how much per day:_____
Do you exercise? Yes No If yes, what is the frequency and type of exercise?_____

What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ Sitting_____ Bending_____ Working at a computer_____

FAMILY HISTORY:

Father: living deceased
Current age if still living:_____ Cause of death and age at death if deceased:_____
Mother: living deceased
Current age if still living:_____ Cause of death and age at death if deceased:_____
Check if applicable to you: As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? Yes No
If yes, please list:_____

FAMILY DISEASES: (Check if applicable and indicate Father, Mother, Sister, Brother):

Tuberculosis____
Cancer____
Mental Illness____
Diabetes ____
Asthma____

Heart Disease ____
Stroke ____
Kidney Disease____
Lung Disease____
Arthritis____

Liver Disease ____
Other____
Explain:_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Active Chiropractic Spine and Joint Center, LLC

Consent for Open Area Treatment Chiropractic Care

Dr. Amanda Lopez, DC

NOTICE: Our office at 7528 4th St. Suite D, Los Ranchos utilizes an open area for treatments, adjustments, and physical therapy. This may result in some of your care or discussions with the doctor being overheard by other patients and staff. All necessary actions will be taken to prevent or limit this during the history and review of the patient's confidential information. You may request a more private situation if you prefer to discuss matters of a sensitive nature. If you have any concerns about your privacy please bring it to the doctor's attention immediately.

Patient's Signature_____ Date_____

Guardian's Signature_____ Date_____

Active Chiropractic Spine & Joint Center, LLC

Dr. Paul Hordes
Dr. Amanda K. Lopez

Financial Policy

We are committed to providing you with the best possible care and we are happy to discuss our professional fees with you at any time. Our goal is to put you back in control of your health and to provide you with high quality health care at a reasonable fee. Your clear understanding of our financial policy is important to our professional relationship.

Private Payments:
Payments are expected at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and American Express. If there is a problem with payment, please let us know immediately. We do not want financial problems to interfere with your care.

Insurance:
We ask for payments at the time of service. We will gladly fill out the necessary insurance forms and file claims for you with insurance carriers that we are preferred providers for. **Exceptions**, we are unable to file claims for any insurance carriers that we are not in network with. The patient is responsible for all referrals, co-payments, and deductibles where applicable. Please refer to your insurance company's agreement for chiropractic care benefits.

Personal Injury:
We will accept Med-Pay (medical coverage on your auto-insurance policy) and Third Party cases. You will need to provide our office with a claim number, phone number and billing address. Med-pay will cover your doctor's bill regardless of who was at fault. We will bill your auto-insurance company for prompt and direct payment for your care, up to your policy limits. If this is a Third Party claim, we would prefer to have an attorney's Letter of Protection. Payment in full is expected upon case settlement. **The patient is ultimately responsible for any and all services rendered.**

Missed Appointments:
Please give our office a minimum of 24 hours notice for any cancellation or rescheduling of an appointment. It is our policy to bill the patient at a rate of $30.00 if proper notice is not given. Special exceptions and emergencies will be taken into consideration. Our office often books appointments up to a week in advance and has a waiting list daily. Please be courteous to your fellow patients and help us to serve you better by keeping your scheduled appointments.

Check Return Policy:
If for any reason this unfortunate situation arises the patient will be charged a $25.00 fee per occurrence.

I, _____ understand and accept the above stipulations and acknowledge that I am financially responsible for the services rendered. I understand and agree that my insurance coverage is a contract between the insurance company and myself. I also understand that if I suspend or terminate my care and treatment, any balance for professional services rendered to me will be immediately due and payable. I also understand that any account 30 days past due will be subject to interest at 1.5% per month (18% annual) retroactive. I will be financially responsible for charges if a collection agency is utilized.

Responsible Party Signature: _____ **Date:** _____

Witness (office personnel): _____

Notice of Informed Consent

Dr. Paul Hordes, DC
Dr. Amanda K. Lopez, DC

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A Subluxation has also been described as an incomplete dislocation of a joint and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral Subluxation with a spinal manipulation, (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping or a clicking sensation in the area being treated.

In our office we use highly trained staff to assist the doctor with portions of your consultation, examination, x-rays, physiotherapy, traction, massage, exercise instruction, and other treatments. Occasionally, when your doctor is not available another clinic doctor will be available to treat you in his place.

Stroke: There is a remote chance (1:6,000,000) of a rare type of stroke associated with manipulation of the cervical spine. The particular adjustment associated with this risk is **NEVER PREFORMED IN THIS OFFICE.**

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally these treatments can irritate this problem, but the treatments administered in this office will not worsen the disc herniations. To help prevent this, patients are put through a specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Because of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, and other treatments may strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution with no long term affects to the patient. These problems, also, occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found attached to the thoracic spine in the middle back. They extend from your back to the front of the chest. Rarely, a chiropractic adjustment may break a rib, this is referred to as a fracture. This occurs only to those patients with weakened bones from such things as osteoporosis, prolonged steroid use, or other bone-weakening diseases. This can be ruled out in the history or the x-rays. We adjust all patients carefully and especially those with bone-weakening conditions. These problems, also, occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely heat or ice can irritate the skin. The result is a temporary increase of skin pain and possible some blistering. These problems, also, occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is not uncommon for spinal adjustments, distraction, massage, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell the doctor or a staff member about it.

Other Problems: There may be other problems or complications that arise from chiropractic treatment other than those mentioned above. These other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore as with any health care delivery system we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care we can deliver and if the results are not acceptable we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

If you have any questions on the above information, please ask your doctor to explain them in more detail. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize Dr. Paul Hordes, DC and whomever he designates to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary on the basis of findings during the set course of treatment.

Patient Signature:_____ **Date:**_____

Patient Name:_____ **Witness:**_____

Consent for Treatment of a Minor: I, the undersigned, hereby authorize Dr. Paul Hordes, DC and whomever he designates to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as they consider therapeutically necessary on the basis of findings during the set course of treatment to

Minor Child's Name:_____ **Parent/Legal Guardian:**_____

Active Chiropractic Spine & Joint Center, LLC
Authorization Form

Dr. Paul Hordes, DC
Dr. Amanda K. Lopez, DC

Authorization is hereby granted to Dr. Paul Hordes, DC and Dr. Amanda K. Lopez, DC to release any information that is acquired in the course of my examination and treatments to any insurance company, attorney, or adjuster. I, _____ authorize and assign direct payment to Active Chiropractic Spine & Joint Center, LLC and Dr. Paul Hordes, DC of any sum I now or hereafter owe this office by my attorney out of the proceeds of any settlement of my case and/or by an insurance company obligated to reimburse me for the charges of these services.

I clearly understand and agree that health and accidental insurance policies are an arrangement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment, and I agree to pay all billing on a timely basis. I also understand that any amount authorized to be paid directly to this office will be applied to any outstanding balance that I owe.

I understand that in personal injury cases payment may be deferred until settlement, with the total due in full at settlement, providing that no other insurance is involved and if an attorney approved by this office is representing me.

I further understand that if I suspend or terminate my treatment in this office or if I discharge my attorney or he/she discontinues my representation, any fees for professional services rendered to me will be **immediately due and payable**. I also agree to pay any and all reasonable legal fees and court cost incurred on the collection of this account.

Limited Power of Attorney: I hereby grant to the physician/facility named above power to endorse upon any checks, drafts, or other negotiable instrument representing payment from any insurance company or attorney's office for payment of treatment and health care rendered by the physician/facility. I agree that any insurance payments representing any amount in excess of charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

Patient Signature: _____ **Minors Name:** _____

Witness: _____ **Parent/Guardian:** _____

Date: _____

Active Chiropractic Spine & Joint Center, LLC
Insurance Policy

Dr. Paul Hordes, DC
Dr. Amanda K. Lopez, DC

We are committed to providing you with the best possible care and will gladly answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and your insurance company. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Assisting in the filing of claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services are rendered.

Payment for services is due at the time the services are rendered. We will be happy to submit claims to your insurance company for payment. However, you are ultimately responsible for any unpaid balances.

Missed Appointment Policy

Broken or missed appointments are a loss to everyone. If you are unable to keep your appointment, please give our office 24 hours notice. Without notice there will be a

$30.00 missed appointment fee!

(this is not billable to insurance)

Patient Signature:_____ **Date:**_____

Active Chiropractic Spine and Joint Center, LLC
Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and consent for use of Health Information

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Dr. Paul Hordes, DC
Dr. Amanda K. Lopez, DC

Name:_____ **Date:**_____
(print Patient's Name)

The undersigned does hereby acknowledge that he or she has received a copy of the Active Chiropractic Spine and Joint Center, LLC Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of the office's HIPAA compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA Compliance Manual, State Law, and Federal Law.

Dated this _____**day** _____**20**_____**By**_____
(Patient's Signature)

If Patient is a minor or under a guardianship order as defined by State Law:

By_____ (signature) **Parent or Guardian** (circle one)

Active Chiropractic
Spine & Joint Center

Permissions and Contact information Update

May we text or call the listed numbers for appointment reminders and billing information? **Y / N**

May we leave messages at these numbers for appointments and billing information? **Y / N**

Is there a spouse or family member we may contact regarding appointments and billing? **Y / N**

If yes, Name:_____ Phone Number:_____

IF APPLICABLE: I give permission for my minor child _____ to be treated by Active Chiropractic Spine and Joint Center in my absence.

_____ _____

Patient Signature Date

Contact information:

Name:_____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Cell Phone Number:_____ Home Phone Number:_____

Email Address:_____