ALIGN
YOUR SPINE
CHIROPRACTIC

859 S YELLOWSTONE HWY STE 301
REXBURG, IDAHO 83440

PATIENT INFORMATION:

NAME: _____ DOB: _____
LAST FIRST M

ADDRESS: _____
STREET APT/UNIT #

_____
CITY STATE ZIP

PHONE: _____ E-MAIL: _____
CELL HOME

CHECK ALL THAT APPLY: ( ) MALE ( ) FEMALE ( ) MINOR ( ) STUDENT ( ) SINGLE ( ) MARRIED

HOW OR FROM WHOM DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION:

COMPANY NAME _____ POLICY # _____ GROUP # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # _____ FAX # _____

POLICY HOLDERS NAME: _____

RELATIONSHIP TO PATIENT _____

DOB _____ MALE _____ FEMALE _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

GUARANTOR INFORMATION IF DIFFERENT FROM PATIENT:

GUARANTOR'S NAME _____ RELATIONSHIP TO PATIENT _____

DOB _____ MALE _____ FEMALE _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INFORMATION FOR AUTO ACCIDENT OR WORKMAN'S COMPENSATION CLAIMS:

EMPLOYERS NAME _____ PHONE # _____ FAX # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CONTACT PERSON _____ E-MAIL _____

DATE OF ACCIDENT _____ JOB RELATED _____ AUTO ACCIDENT _____

AUTHORIZATION/CLAIM # _____ ADJUSTERS NAME _____

ALIGN
FOUNDATIONS
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SYMPTOMS:

DATE OF ONSET_____ CAUSE OF SYMPTOMS_____

WHERE SPECIFICALLY IS THE PROBLEM/PAIN LOCATED_____

IS THIS CONDITION PROGRESSIVELY GETTING WORSE? _____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:

- ☐ HEADACHES
- ☐ CONCENTRATION
- ☐ JAW PAIN
- ☐ WAKE YOU FROM SLEEP
- ☐ CAUSE YOU TO MISS WORK/SCHOOL
- ☐ INDIGESTION OR HEARTBURN
- ☐ NAUSEA OR VOMITTING
- ☐ BLURRED OR DOUBLE VISION
- ☐ RINGING IN EARS

FREQUENCY OF SYMPTOMS:

- ☐ CONSTANTLY (76-100 %)
- ☐ OCCASIONALLY (26-50%)
- ☐ FREQUENTLY (51-75%)
- ☐ INTERMITTENTLY (0-25%)

NATURE OF SYMPTOMS:

- ☐ BURNING
- ☐ ACHING
- ☐ NUMB
- ☐ SHOOTING
- ☐ STABBING
- ☐ SHARP
- ☐ TINGLING
- ☐ THROBBING
- ☐ TIGHT

PAIN INTENSITY:

USING A SCALE OF 1 TO 10, RATE YOUR PAIN (1 BEING MILD AND 10 BEING SEVERE)

1 2 3 4 5 6 7 8 9 10

WHAT MAKES THE SYMPTOMS WORSE:

- ☐ LIFTING
- ☐ WORK
- ☐ SITTING
- ☐ TRAVELING
- ☐ READING
- ☐ DRIVING
- ☐ STANDING
- ☐ PERSONAL CARE
- ☐ HEADACHES
- ☐ RECREATION
- ☐ SLEEPING
- ☐ CONCENTRATING
- ☐ WALKING
- ☐ SOCIAL LIFE

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WHAT MAKES THE SYMPTOMS BETTER:

- ☐ REST
- ☐ STRETCHING
- ☐ ICE
- ☐ HEAT
- ☐ LYING ON STOMACH
- ☐ LYING ON BACK
- ☐ LYING ON LEFT SIDE
- ☐ LYING ON RIGHT SIDE

MEDICAL HISTORY:

ARE YOU PREGNANT? ____ YES ____ NO

LIST ALL SURGURIES: _____

TRAUMAS/FRACTURES_____

CURRENT MEDICATIONS_____

ALLERGIES_____

ANYTHING ELSE WE SHOULD KNOW ABOUT? _____

DO YOU USE ALCOHOL? ____YES ____ NO IF YES HOW MUCH PER WEEK? _____

DO YOU SMOKE? ____ YES ____ NO IF YES HOW MANY PACKS PER WEEK? _____

DO YOU EXERCISE? ____ YES ____ NO IF YES HOW OFTEN? _____

FAMILY HISTORY: PUT (P) FOR PATIENT, (M) FOR MOTHER, (F) FOR FATHER, (S) FOR SIBLING

____ AIDS/HIV	____DIABETES	____LIVER DISEASE	____PROSTATE PROBLEMS
____ALLERGY SHOTS	____EMPHYSEMA	____MEASLES	____RHEUMATOID ARTHRITIS
____ANEMIA	____EPILEPSY	____MIGRAINE HEADACHES	____RHEUMATIC FEVER
____APPENDICITIS	____SCARLETT FEVER	____MONONUCLEOSIS	____SCARLET FEVER
____ARTHRITIS	____DEPRESSION	____MULTIPLE SCLEROSIS	____STROKE
____BLEEDING DISORDER	____GLAUCOMA	____MUMPS	____THYROID PROBLEMS
____BRONCHITIS	____GOUT	____OSTEOPOROSIS	____TONSILLITIS
____CANCER	____HEART DISEASE	____PACEMAKER	____TUBERCULOSIS
____CATARACTS	____HEPATITIS	____PARKINSONS DISEASE	____ULCERS
____CHICKEN POX	____HERNIA	____ PNEUMONIA	____WHOOPING COUGH
____HERNIATED DISC	____HIGH CHOLESTEROL	____POLIO	____HEART ATTACK

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HIPPA COMPLIANCE PATIENT CONSENT FORM

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION. THE NOTICE CONTAINS A PATIENTS RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU ASCERTAIN THAT BY SIGNATURE THAT YOU HAVE REVIEWED OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF THE NOTICE MAY CHANGE, IF SO, YOU WILL BE NOTIFIED AT YOUR NEXT VISIT TO UPDATE YOUR SIGNATURE/DATE. YOU HAVE THE RIGHT TO RESTRICT HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATONS. WE ARE NOT REQUIRED TO AGREE WITH THIS RESTRICTION, BUT IF WE DO, WE SHALL HONOR THISAGREEMENT. THE **HIPPA** (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) LAW ALLOWS FOR THE USE OF THE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION AND POTENTIALLY ANONYMOUS USAGE IN A PUBLICATION. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING, SIGNED BY YOU. HOWEVER, SUCH REVOCATION WILL BE RETROACTIVE.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.
- THE PRACTICE RESERVES THE RIGHT TO CHANGE THE PRIVACY POLICY AS ALLOWED BY LAW.
- THE PRACTICE HAS THE RIGHT TO RESTRICT THE USE OF THE INFORMATION BUT THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS.
- THE PATIENT HAS THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME AND ALL FULL DISCLOSURES WILL THEN CEASE.
- THE PRACTICE MAY CONDITION RECEIPT OF TREATMENT UPON EXECUTION OF THIS CONSENT

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME OR ON YOUR CELL? ____YES ____NO
MAY WE DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR FAMILY? ____YES ____NO

IF YES, PLEASE NAME THE MEMBERS ALLOWED.

_____

_____

PATIENTS PRINTED NAME_____**DATE**_____

SIGNATURE OF PATIENT/GUARDIAN_____**DATE**_____

WITNESS SIGNATURE_____**DATE**_____

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CHIROPRACTIC HAS ONE OF THE SAFEST RECORDS OF ALL FORMS OF HEALTHCARE. SERIOUS COMPLICATIONS ARE VERY RARE BUT THEY ARE POSSIBLE. OUR DUTY IS TO INFORM YOU OF POTENTIAL SIDE EFFECTS AND/OR COMPLICATIONS THAT ARE RARELY ASSOCIATED WITH ANY FORM OF TREATMENT INCLUDING CHIROPRACTIC CARE. SORENESS OR MUSCLE TIGHTNESS ARE THE MOST COMMON NEGATIVE BUT ARE USUALLY A BRIEF REACTION TO THE TREATMENT. POSSIBLE SIDE EFFECTS OF THE ADJUSTMENT MAY INCLUDE REACTIVE MUSCLE SPASM, INJURY TO DISC, PRESSURE ON THE NERVE TISSUE, FRACTURES TO WEAKENED BONES, AND INJURY TO ARTERIES RESULTING IN A STROKE.

I AUTHORIZE ALIGN YOUR HEALTH CHIROPRACTIC TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY TO ANY PHYSICIAN, HOSPITAL, MEDICAL CARE FACILITY, OR DESIGNATED INSURANCE CARRIER. I ALSO AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION ON MY PAST HISTORY AND TREATMENT TO ALIGN YOUR HEALTH CHIROPRACTIC. I ALSO SIGN AND AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO ALIIGN YOUR HEALTH CHIROPRACTIC. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL WRITTEN NOTICE IS GIVEN REVOKING SAID AUTHORIZATION. **WE ALSO REQUIRE CO PAYMENT AT THE TIME SERVICES ARE RENDERED.**

BY SIGNING BELOW I UNDERSTAND THAT ALL FINANCIAL OBLIGATION FOR ALL TREATMENT RECEIVED IS THE PATIENTS RESPONSIBILITY, REGARDLESS OF INSURANCE COVERAGE, ATTORNEY LEINS, 3RD PARTIES,OR SETTLEMENTS.

I ACKNOWLEDGE THAT I FULLY UNDERSTAND AND AGREE TO ALL POLICIES AND PROCEDURES STATED ABOVE AND THAT ALL THE INFORMATION PROVIDED IS CORRECT AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENTS PRINTED NAME_____**DATE**_____

PATIENT/GUARDIANS SIGNATURE_____**DATE**_____