CONFIDENTIAL PERSONAL HEALTH HISTORY

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip:_____ Work Phone: _____

DOB: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Your SSN: _____ Email Address: _____

How Did You Hear About Us? (Name of person or Company) _____

Spouses Name: _____ Number of Children: _____

Please circle: Single Married Divorced Separated Widowed Partnered

Business/Employer: _____ Type of Work: _____

Please list your chief health complaints, symptoms, or concerns in the order of their severity below:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Are your symptoms: ☐ Improving ☐ Getting worse ☐ About the same ☐ Irregular

Check off the activities that aggravate your condition:

☐ Standing ☐ Walking ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing

Have you seen another doctor for this condition? ☐ Yes ☐ No

If yes, Dr. name: _____ Date Consulted:_____Diagnosis: _____

Have you ever had an MRI of your spine? ☐ Yes ☐ No

If yes, name of facility_____ Date of MRI: _____

Are you disabled from work? ☐ Yes ☐ No If yes, please give dates:_____

Medications you currently take: _____

Is your condition due to a(n): ☐ Auto Accident ☐ Work Injury ☐ Sport Injury ☐ Unknown ☐ Pregnancy ☐ Other

Date of Accident or Injury: _____ Where did it occur? ☐ Auto Accident ☐ Work Injury ☐ Business ☐ Other

Please list all major accidents, injuries or falls you have had in your lifetime **(or write none)**:

_____

_____

Date:

Name: _____ Date: _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of Your Care.

Please check any of the following diseases or conditions you have had:

__Pneumonia
__Rheumatic fever
__Polio
__Tuberculosis
__Whooping cough
__Mumps
__Smallpox
__Chicken pox
__Diabetes
__Cancer
__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental disorder
__Anemia
__Auto immune disease
__Heart disease
__Thyroid
__HIV positive
__Eczema
__Measles
__Lumbago
__Asthma
__Kidney Stones

Please check ✓ the line of symptoms you have had in the past 6 months
Then circle ○ the symptoms you are experiencing at the present time:

MUSCULO-SKELETAL SYSTEM
__Head Pain/ Problems
__Neck Pain/Problems
__Shoulder Pain/Problems
__Arm Pain/Problems
__Hand Pain/Problems
__Mid Back Pain/Problems
__Chest Pain/Problems
__Stomach Pain/Problems
__Low Back Pain/Problems
__Hip Pain/Problems
__Leg Pain/Problems
__Foot Pain/Problems
__Walking Pain/Problems
__Chewing/ Jaw Pain/Problems
__General Stiffness

NERVOUS SYSTEM
__Nervousness
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion / Depression
__Fainting
__Convulsions
__Cold/Tingling Extremities
__Muscle Cramping
__Stress

GENERAL SYSTEM
__Fatigue
__Allergies
__Fever
__Headaches
__Migraine Headaches
__Tension Headaches
__Sinus Headaches
__Loss of Sleep

GENETO-URINARY SYSTEM
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine
__Bed-Wetting

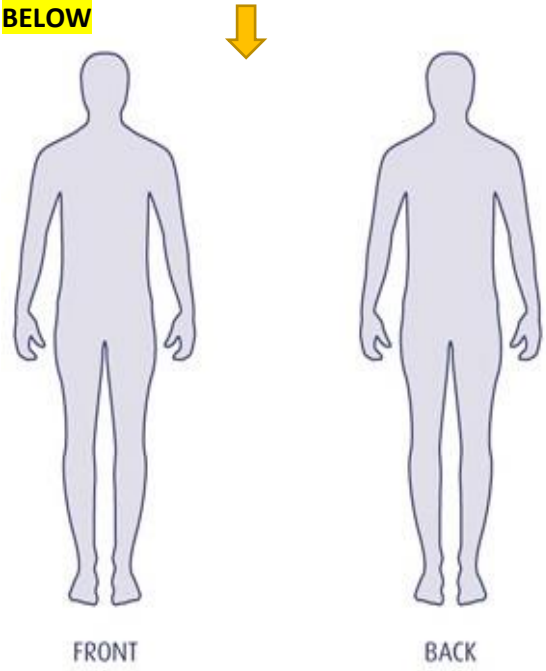
GASTRO-ENTESTINAL SYSTEM
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gall Bladder Problems
__Heartburn/ Indigestion
__Black/ Bloody Stool
__Colitis

EARS, EYES, NOSE & THROAT
__Sinus Problems
__Vision Problems
__Dental Problems
__Sore Throat
__Earaches
__Ringing in Ears
__Hearing difficulty
__Stuffed Nose

MALE/FEMALE
__Menstrual irregularity
__Menstrual cramping
__Vaginal pain/ infections
__Breast pain/lumps
__Prostate/sexual dysfunction

CARDIO-VASCULAR RESPIRATORY
__Chest Pain
__Shortness of Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/congestion
__Varicose Veins
__Ankle swelling
__Stroke

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW



Major Surgery or Operations you have had and dates **(or write none)**:

_____

Reasons for hospitalizations (other than above): _____

Name: _____ Date: _____

Daily Lifestyle and Habits: (Circle all that applies)

Alcohol	Daily	Weekly	Monthly	None
Coffee	>5 cups	2-4 cups	1 cup	None
Tobacco	>2 packs	1 pack	<1/2 pack	None
Drugs	Daily	Weekly	Monthly	None
Exercise	Daily	Weekly	Monthly	None
Sleep	>10 hrs.	7-10 hrs.	1-7 hrs.	<4 hrs.
Appetite	Heavy	Moderate	Light	None

Do you wear:

☐ Heal Lift ☐ Foot Pads ☐ Innersoles ☐ Arch Supports

Insurance Information:

Do you want us to file with your insurance? ☐ Yes ☐ No

☐ Health insurance ☐ Medicare ☐ Group ☐ Attorney

FEMALES ONLY:

First day of last cycle: _____

Currently Pregnant? ☐ Yes ☐ No ☐ Maybe

If pregnant, how many weeks?_____

Due Date: _____/_____/_____ ☐ Girl or ☐ Boy

Who is your OBGYN/Midwife/Doula?

_____

Please Sign: _____

***In case of an emergency, please give the name of a relative or close friend who lives in Louisiana:**

_____	_____	_____
Name	Relationship to patient	Contact Phone Number

*Do you authorize the release of the following health information to your emergency contact listed above?

Check each box that applies below:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. ☐ Yes ☐ No
- Able to make, reschedule, or cancel appointments for me ☐ Yes ☐ No
- Billing and statement information ☐ Yes ☐ No

PLEASE READ: Redisclosure: I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion, and it is placed in collections.

I understand if I have an unpaid balance to Enhanced Life Chiropractic and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so, incurred during collection efforts.

In order for Enhanced Life Chiropractic or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Enhanced Life Chiropractic and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (*ii)* contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (*iii*) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device as applicable.

_____	_____	_____
Signature of Patient or Legal Guardian	**Print** Patient's Name or Legal Guardian	Date

Enhanced Life Chiropractic

HIPAA FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Enhanced Life Chiropractic Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Enhanced Life Chiropractic, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Enhanced Life Chiropractic, LLC. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Enhanced Life Chiropractic, LLC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Jeffrey Franco DC.

With this consent, Enhanced Life Chiropractic, LLC. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Enhanced Life Chiropractic LLC. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Enhanced Life Chiropractic LLC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Enhanced Life Chiropractic LLC . restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Enhanced Life Chiropractic LLC. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Enhanced Life Chiropractic LLC. may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal Guardian **Print** Patient's Name or Legal Guardian Date

Enhanced Life Chiropractic

Informed Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) **Stroke:** Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise for the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive date to quantify probability.

2) **Disc Herniations:** Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors: Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.

3) **Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

4) **Rib Fractures:** The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from things as osteoporosis on their x-rays.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all of these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

Informed Consent

I hereby authorize and direct Dr. Jeffrey Franco, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustments, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____ _____

Signature of Patient or Legal Guardian **Print** Patient's Name or Legal Guardian Date

PATIENT OPTIONS ACCESS PROGRAM
FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one-year (12 months) from the date of signature below. You will automatically be reenrolled for successive one-year (12 month) periods unless request in writing.

There are no fees, dues, charges, or other consideration required for participation.

DISCLOSURES:

· The Program provides discounts to you from contracted healthcare providers for services rendered.

· The Program participant is obligated to pay for all healthcare services directly as de facto 3rd party to provider but will receive a contractual discount from healthcare providers who have contracted with Patient Options.

·This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where another third-party insurance company is responsible for charges.

· Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement.

· The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.
I have read and agree to the terms and conditions set forth above:

Name: _____ Signature: _____

Address: _____ Date: _____

_____

_____

**Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Enhanced Life Chiropractic

Patient Financial Responsibility Disclosure Form

Insurance Disclaimer: “A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.” We will provide an estimate of your benefits to the best of our ability, however, this estimate is not a guarantee of coverage. Any denials or additional fees from your insurance will be the patient’s responsibility.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be “reasonable and necessary.” Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____	_____	_____
Signature of Patient or Legal Guardian	**Print** Patient’s Name or Legal Guardian	Date

ENHANCED LIFE CHIROPRACTIC

1403 Derek Dr. Hammond, LA 70403 Dr. Jeffrey Franco (985) 222-2712

ACTIVITIES OF DAILY LIVING QUESTIONAIRE

Rate the following activities using the pain scale of 0-10, with 0 meaning you have no pain or difficulty and 10 being you're unable to perform the activity at all. Please understand that using a number higher than 10 is not acceptable.

ACITIVITY	INITIAL	RE-EXAM ONE	RE-EXAM TWO	RE-EXAM THREE
Date of Exam				
Lifting				
Bending				
Standing				
Lying				
Walking				
Twisting				
Coughing				
Sneezing				
Sitting				
Driving				
PATIENT INITIALS				
Additional Comments:				

_____ _____ _____

Patient Name Signature of Patient or Legal Guardian Date

ENHANCED LIFE CHIROPRACTIC

X-Ray Consent Form

Patient Consent to X-Ray

I hereby authorize the performance of diagnostic x-rays. The Chiropractic Physician has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Patient Name: _____ Date: _____

Patient Signature: _____

Consent to X-Ray a Minor

I am the parent or legal guardian of _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Chiropractic Physician has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Name of **Parent or Legal Guardian**: _____ Date:_____

Signature of **Parent or Legal Guardian**: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The Chiropractic Physician has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Patient Name: _____ Date: _____

Patient Signature: _____