Name _____
Address _____
City _____ State _____ Zip _____
Phone _____
Cell Phone _____
SS# _____-_____-_____ # Children _____
Employer _____
Occupation _____

Primary insurance _____
Subscriber date of birth _____

Sex: M F Marital Status: M S W D
Date of Birth: _____ Age: _____
Spouse Name _____
Referred By _____
Reason for choosing our office: _____
_____
Work Phone _____
Family Physician: _____

Secondary Insurance _____
Subscriber date of birth _____

Was this accident / injury result of: Auto Work Other
Date of Injury: _____

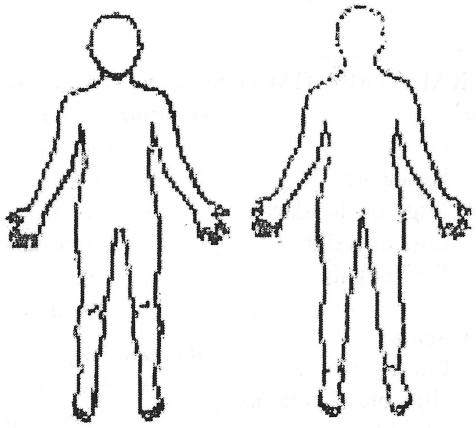
Describe injury or complaint and what you think caused it:

_____
_____
_____
_____

List other doctors consulted for this condition(s):
Doctor's Name: _____
When Consulted? _____ Diagnosis _____
Treatment: _____
List serious accidents, falls, or broken bones: _____
_____ When? _____
Were you ever knocked unconscious? Yes No
Explain: _____

Mark with an X where the pain is located

Front Back



Put an X on the number that best describes the level of your pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Mid Pain Moderate Pain Severe Pain

Habits

Have you ever smoked? Yes No
Smoking _____ packs/day _____years
Alcoholic beverages _____ per week
Coffee _____ cups per day
Sleep _____ hours per night
Exercise _____ times per week

Family History

Put an X on the appropriate Line

	Diabetes	Heart	Kidney	Cancer	Back
Father	____	____	____	____	____
Mother	____	____	____	____	____
Brother	____	____	____	____	____
Brother No of ___	____	____	____	____	____
Sister No of ____	____	____	____	____	____

Please list the medications and vitamins or food supplements you are taking:

(including prescription drugs, birth control, and over the counter drugs like aspirin, cough syrup, etc.)

1. _____ For: _____ Approximately how long? _____
2. _____ For: _____ Approximately how long? _____
3. _____ For: _____ Approximately how long? _____
4. _____ For: _____ Approximately how long? _____
5. _____ For: _____ Approximately how long? _____

List Allergies: (medicine, dust, ragweed, certain foods)

1. 2.

3. 4.

Check (X) any of the following illnesses or diseases you have or have had:

☐ Diabetes	☐ Chicken pox	☐ High cholesterol	☐ Arthritis
☐ Cancer	☐ Polio	☐ Tuberculosis	☐ Influenza
☐ Heart Attack	☐ Appendicitis	☐ Rheumatoid arthritis	☐ Whooping cough
☐ Stroke	☐ Chronic cough	☐ Anemia	☐ Epilepsy
☐ Kidney Stones	☐ Measles	☐ Goiter	☐ Pleurisy
☐ Prostate problems	☐ Mumps	☐ Osteoporosis	☐ Pneumoni

NECK, BACK, EXTREMITY Check (X) conditions you presently have or have had in the <u>past year</u>.

Neck & Shoulders	*Mid-Back*	*Arms & Hands*	*Hips, Legs & Feet*
☐ Pain in neck	☐ Mid-back pain	☐ Pain down arm	☐ Pain in buttocks
☐ Neck Stiffness	☐ Pain between shoulder blades	☐ Pain/numbness in hand	☐ Pain/numbness down leg
☐ Grinding/popping sounds in neck	☐ Mid-back stiffness	*Low Back*	
		☐ Low back pain	
		☐ Low back stiffness	

GENERAL SYMPTOMS Check (X) conditions you presently have or have had in the <u>past year</u>.

General	*Gastrointesinal*	*Eyes, Ear, Nose, Throat*	*Genito-Urinary*
☐ Fever	☐ Constipation	☐ Blurred vision	☐ Blood in urine
☐ Headache	☐ Diarrhea	☐ Earache	☐ Frequent urination
☐ Migraine headaches	☐ Excessive thirst	☐ Loss of hearing	☐ Painful irination
☐ Loss of weight	☐ Stomach pain	☐ Ringing in ears	☐ Difficulty starting and/or stopping urine
☐ Weight gain	☐ Ulcers	☐ Nosebleeds	
	☐ Blood in stool	☐ Dizziness	

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

Women Only
- ☐ Menstrual pain
- ☐ Abnormal bleeding
- ☐ Menopause

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Please list the surgeries and hospitalizations that you have had and their appropriate dates:

1.	Date:	Doctor:
2.	Date:	Doctor:
3.	Date:	Doctor:
4.	Date:	Doctor:

List past illnesses: (heart attack, thyroid, kidney, etc.)

1.	Date:	Doctor:
2.	Date:	Doctor:

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance and this office. If there is a deductible co-pay, or percentage coverage – I agree to pay my portion as services rendered, unless other arrangements have been made. However, I understand that I am ultimately responsible for payment in full at this office. In the event default payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian's Signature Authorizing Care Date

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship or authority of patient's representative

_____
date signed

To be completed by doctor or staff

_____
witness to patient's signature

_____
translated by

To be completed by doctor or staff

_____
date

_____
date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND

COMMUNITCATION PREFERENCES AND AUTHORIZATION

Please read the following and initial at each paragraph:

_____ I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for seven (7) years unless I provide written notice to revoke this authorization. I understand that I have certain rights to privacy regarding my protected health information. I understand that is information can and will be used in the following ways:

- Conduct, plan, and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____ I understand that the staff at Doubleday's Spine & BRAIN of Southwest Michigan may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

_____ I understand that Doubleday's Spine & BRAIN of Southwest Michigan utilizes phone calls, text messaging and e-mail messaging for appointment reminders and or missed appointments. I authorize the staff at Doubleday's Spine & BRAIN of Southwest Michigan to contact me with these reminders and leave a voice mail message if necessary.

Patient

Signature Date

Witness Date

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN _____ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT

_____ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT _____ OTHER AS SPECIFIED_____

APPOINTMENT CANCELLATION/ NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. In the instance that an appointment is not cancelled at least 12 hours in advance we reserve the right to charge a thirty dollar ($30) fee.

Thank you for understanding.

Name

Signature Date

Staff/Witness Date

Doubleday's Spine & B.alance, R.ehabilitation, A.dvanced, I.ntegrated, N.eurology of Southwest Michigan
FEEL THE DIFFERENCE.

Payment Policy

ALL PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

As a courtesy, Doubleday's Spine & BRAIN of Southwest Michigan, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the way that the plan processes and will not honor the benefit quote we received. It is the policy of Doubleday's Spine & BRAIN of Southwest Michigan that payment is **DUE AT THE TIME OF SERVICE** unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay, and/or coinsurance payment at the conclusion of each visit. You may be billed for any outstanding balances.

If you are covered by health insurance, we will be happy to bill your insurance. It is the responsibility of the patient to ensure that Doubleday's Spine & BRAIN of Southwest Michigan has the correct insurance information and also to update this information as it changes. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. We do not participate with Blue Care Network (BCN), Priority HMO. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover services provided at Doubleday's Spine & BRAIN of Southwest Michigan. Please remember that you are **100%** responsible for all charges incurred and that your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend that you also contact your insurance carrier and check into your coverage for chiropractic services, massage (performed by a massage therapist), mechanical/manual traction, myo-facial release, therapeutic exercise, and/or therapeutic exercises/activities, x-ray. We do not bill secondary insurance unless you are a patient that has Medicare as a primary insurance. Do not assume that you will not owe anything if you have more than one insurance policy.

Agreement: By signing this agreement I agree to the terms as outlined in the above paragraphs.

_____

Patients Name/ Date

_____

Staff/Witness/ Date