Welcome To Imagine Wellness Chiropractic Center

First Name_____ MI ____ Last _____ Today's Date____/____/____

Address_____ City_____ State_____ Zip_____

Birth Date____/____/____ Age_____ Soc. Sec. #_____-_____-_____ Male ____ Female____ # of Children _____

Home # ( )_____ Cell # ( )_____ Cell Carrier:_____ Work# ( )_____

Can We leave messages and/or texts: Y / N E-mail Address _____

Your occupation _____ Work duties _____ Employer: _____

□Single □Married □Significant Other □Widowed □Separated □Divorced **Are you a student: Y / N** ***WOMEN: Are you pregnant? Y / N**

Name of Spouse/Parent if patient is under 18_____ Birth Date of Spouse/Parent if patient is under 18 _____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Who may we thank for referring you to our office? _____ Are you using a HSA, HRA, or FLEX? _____

Primary Insurance:_____ **Policy Holder Name**: _____ Date of Birth: _____

Phone Number:_____ Address: _____

Patient Covered: _____ Patient's Relationship To Insured: Self _____Spouse_____ Child_____

Your deductible amount?_____ Co-Pay Amount? _____Has your deductible been met this year?_____

*****FOR PRESENT CONDITIONS MARK "X", PAST CONDITIONS MARK "P" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both

___Numbness/Tingling/Pain in (Buttocks/Thighs/Legs/Feet/Toes R / L Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness/ Pain	___Back Stiffness/Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Asthma/Emphysema
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/ Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problem
___Prostate Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness/Vertigo	___Buzzing/Ringing in ears	___Sinus Problems	___Nervousness/Anxiety
___Fatigue	___Depression	___ Irritability/Mood Swings	___Tension/Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold feet	___Bed Wetting	___Recurring Infection	___Diarrhea/Constip./Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw/TMJ Problems
___Cold Sweats	___Light Bothers Eyes	___Problems Urinating	___Heartburn/Reflux
___High Blood pressure	___PMS	___Menopause	___Ulcers
___Other	___Thyroid Problems	___Allergies	___ Cancer (Type)_____

Additional Explanation:

Current Health Condition

Please identify the condition(s) that brought you to this office:

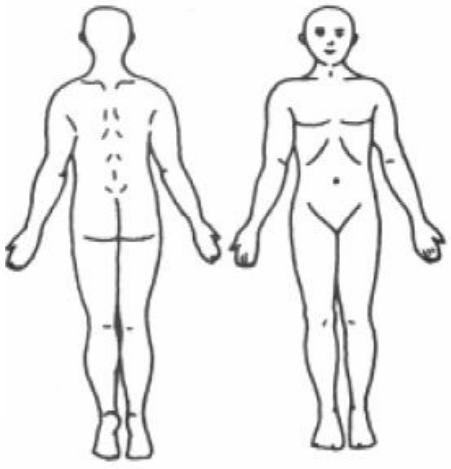
Primarily:_____

Secondarily: _____

Third: _____

Please mark on the diagram below the area of discomfort:

R = Radiating **B = B**urning **D = D**ull **A =** Aching
N = Numbness **S = S**harp/ **S**tabbing **T= T**ingling



On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by c*ircling the number*:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____

How did the injury happen?_____

What relieves your symptoms? _____

What makes them feel worse? _____

Timing: When Is it worse? □ Worse AM □ Worse PM □ Worse W/ Activity □ Worse Sleeping
How often it occurs? □ Occasional (0-25%) □ Intermittent (25-50%) □ Frequent (50-75%) □ Constant (75-100%)

Daily Activities: Effects of Current Condition on Performance

Changing Positions	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Computer Use	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting/Bending	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Reading/Concentration	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing/Shaving	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking /Running	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

□Are there any other conditions that the doctor should address? If so, list and describe**:**_____

Medications: What medications are you currently taking and for **what conditions?** _____

_____

Supplements: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____
When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment _____
Who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem and **YEAR**:

	How long ago	Type of care received
Injuries (broken bones, dislocations, ect.)		
Surgeries		
Childhood disease		
Adult disease (Diabetes, Arthritis, Cerebral Vascular, heart attack, cancer, tumors, ect.)		

Family History
Is there history if any of the following conditions? (Indicate family member including , parents , grandparents, & siblings)
□ Heart Disease _____ □ Diabetes _____ □ Cancer _____ □ Arthritis _____ □ Other

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Hobbies -Recreational Activities- Exercise Regime: How is it affected? _____

On this scale mark where your health is: Optimal Health (feeling healthy) 1 2 3 4 5 6 7 8 9 10 (Feeling Unhealthy) Degenerating Health

How would good health help you live a fulfilling life? Example: have energy to play with children/ grandchildren, improved golf game/ sports ability, more focused, improved quality of life, increased stamina) _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Imagine Wellness Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date
☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.
By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature

Imagine Wellness Chiropractic Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Sherrie at (623) 582-8951 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____

Imagine Wellness Chiropractic Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Imagine Wellness Chiropractic Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient signature Date

_____ _____

Witness Date

Insurance Subscriber Acknowledgement Form

Medical insurance procedures vary regarding reimbursement for services covered. They may pay us, the provider, directly or they may pay you, the subscriber. In order to make your situation with the insurance company more convenient, we have offered to bill for the services you receive in our office and not collect payment for these services at the time they are provided, except for your co-pays. All insurance correspondence and claim information will be sent to **you, the patient/subscriber**. Our clinic WILL receive notification of claim status, amount covered from your insurance and whether the reimbursement (payment for services rendered) was sent **to you, the patient**.

Initial the following statements in acknowledgement of your understanding of each statement:

_____ If you receive a payment from _____, please bring the payment and any insurance correspondence to our office **immediately** for the reconciliation of your account. Your insurance correspondence may include an Explanation of Benefits (EOB), a check, a letter of information, etc.

_____ If the checks for your insurance claims are not provided, the patient/subscriber is responsible for the entire balance of each claim (**no discounts would apply**.)

If you have any questions, please contact our office at 623-582-8951.

_____ _____

(Print Name) (Date)

_____

(Signature)

_____

(Staff)

OUR OFFICE POLICIES

Welcome to Imagine Wellness Chiropractic Center!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*****,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

☐ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Imagine Wellness Chiropractic Center** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors utilize Palmer, Activator, and Thompson Drop and a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

_____ _____

Patient signature Date

_____ _____

Witness Date

No Show Policy

The staff at Imagine Wellness Chiropractic Center respects your time and we ask for the same courtesy. Missed appointments/no shows affect our ability to provide timely attention to our patients. When a patient does not *show up* for their appointment, another patient loses an opportunity to be seen.

If you are unable to make your appointment, we respectfully ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or *no show*.

Protocol for *No Shows:*

The first *no show* will be followed up with a call reminding you of our missed appointment policy. If you fail to attend two consecutive appointments, you will be charged a $25 *no show* fee and a second call to you will be made.

Repeated cancellations and *no shows* could result in a discharge from our clinic. You are directly responsible for payment of the *no show* fee on or before your next appointment. The *no show* fee cannot be billed to your insurance company.

Patient Name:_____ Date:_____