


ChiroPros

DATE: _____ Referred By: _____

## PATIENT INFORMATION

Name: _____ ☐ M ☐ F Birthdate: ___/___/___ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: ___-___-___ ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Home #: _____ Cell #: _____ Email: _____

Preferred contact method: ☐ Home ☐ Work ☐ Cell
Are you interested in receiving text or email appt. reminders? ☐ Y ☐ N

Spouse's Name: _____ Do you have children? ☐ Y ☐ N How Many? _____

RACE: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

ETHNICITY: ☐ American Indian ☐ Asian ☐ Black, African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Decline

**How are we going to help you?** _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

## INSURANCE INFORMATION

Insurance Company: _____ Contract No. _____ Group No. _____
Insured: _____

## OCCUPATION

Employer Name: _____ Employer Phone No. _____

Occupation: _____ My job duties include: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

## PATIENT COMPLAINTS (Please check all that apply)

| Current | Past | | Current | Past | | Current | Past | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Neck pain | ☐ | ☐ | Mid back pain | ☐ | ☐ | Foot Numbness ☐L / ☐R |
| ☐ | ☐ | Neck Stiffness | ☐ | ☐ | Mid back stiffness | ☐ | ☐ | Constipation |
| ☐ | ☐ | Headaches | ☐ | ☐ | Shoulder pain ☐L / ☐R | ☐ | ☐ | Poor circulation |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Shoulder tightness ☐L / ☐R | ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Head feels heavy | ☐ | ☐ | Rib pain ☐L / ☐R | ☐ | ☐ | Asthma |
| ☐ | ☐ | Twitching of face | ☐ | ☐ | Pain in side ☐L / ☐R | ☐ | ☐ | Loss of balance |
| ☐ | ☐ | Grating in neck | ☐ | ☐ | Chest Pain ☐L / ☐R | ☐ | ☐ | Loss of taste |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ Muscle spasms in neck | ☐ | ☐ Low back pain | ☐ | ☐ Fatigue |
| ☐ | ☐ Arm pain ☐L / ☐R | ☐ | ☐ Low back stiffness | ☐ | ☐ Nervousness |
| ☐ | ☐ Arm Numbness ☐L / ☐R | ☐ | ☐ Hip pain ☐L / ☐R | ☐ | ☐ Sleeping trouble |
| ☐ | ☐ Wrist pain ☐L / ☐R | ☐ | ☐ Leg pain ☐L / ☐R | ☐ | ☐ Arthritis |
| ☐ | ☐ Hand Numbness ☐L / ☐R | ☐ | ☐ Leg numbness ☐L / ☐R | ☐ | ☐ Painful joints |
| ☐ | ☐ Cold Hands ☐L / ☐R | ☐ | ☐ Knee pain ☐L / ☐R | ☐ | ☐ Swollen joints |
| ☐ | ☐ Pain in ears ☐L / ☐R | ☐ | ☐ Pain in feet ☐L / ☐R | ☐ | ☐ Menstrual irregularity |

## HISTORY

Are your complaints related to an accident? ☐ yes ☐ no If yes, ☐ work related ☐ auto ☐ other _____

Does your pain interfere with your? ☐ Work ☐ Sleep ☐ Daily Routines ☐ Recreation

Is it possible that you are pregnant? ☐ no ☐ yes

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

## Please indicate what treatment/testing you have already received for these complaints

☐ Chiropractic ☐ Physical Therapy ☐ Medications ☐ Surgery ☐ MRI ☐ CT Scan ☐ X-rays

☐ Other _____

## Please indicate which doctors you have already seen for these complaints

Doctor: _____ City _____ Phone No. _____

Doctor: _____ City _____ Phone No. _____

Doctor: _____ City _____ Phone No. _____

## SURGERIES

| Surgery | Month/Year | Surgery | Month/Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you had any of the following:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Anemia | ☐ | ☐ | Anxiety |
| ☐ | ☐ | Bleeding disorders | ☐ | ☐ | Cancer | ☐ | ☐ | Chemical dependency |
| ☐ | ☐ | Depression | ☐ | ☐ | Diabetes | ☐ | ☐ | Epilepsy/Siezures |

☐ ☐ Fractures
☐ ☐ Hernia
☐ ☐ Multiple sclerosis
☐ ☐ Parkinson's disease
☐ ☐ Prosthesis
☐ ☐ Suicide attempt
☐ ☐ Ulcers

☐ ☐ Heart disease
☐ ☐ Herniated disc
☐ ☐ Osteoporosis
☐ ☐ Polio
☐ ☐ Psychiatric care
☐ ☐ Thyroid problems
☐ ☐ Other _____

☐ ☐ Hepatitis
☐ ☐ High cholesterol
☐ ☐ Pacemaker
☐ ☐ Prostate problems
☐ ☐ Stroke
☐ ☐ Tumors

## MEDICATIONS, VITAMINS, AND SUPPLEMENTS

| Medication | Dosage (ex. Mg) | Vitamin/Supplement | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to anything? ☐ No ☐ Yes (if "YES" please list any and all allergies)

## ALLERGIES & MEDICATION ALLERGIES

ALLERGIC TO:_____ REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

ALLERGIC TO:_____ REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

## SOCIAL

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None ☐ Interested

My habits include: ☐ Smoking/Tobacco use _____packs/day (current smoker) ☐ never smoked ☐ former smoker

☐ Alcohol _____drinks/week

☐ Coffee _____cups/day ☐ Soda Pop _____cups/day ☐ Tea _____cups/day

☐ Interested in Personal Training/Nutrition? _____

## FAMILY

*Please mark the conditions that relate to your parents, siblings, or grandparents.*

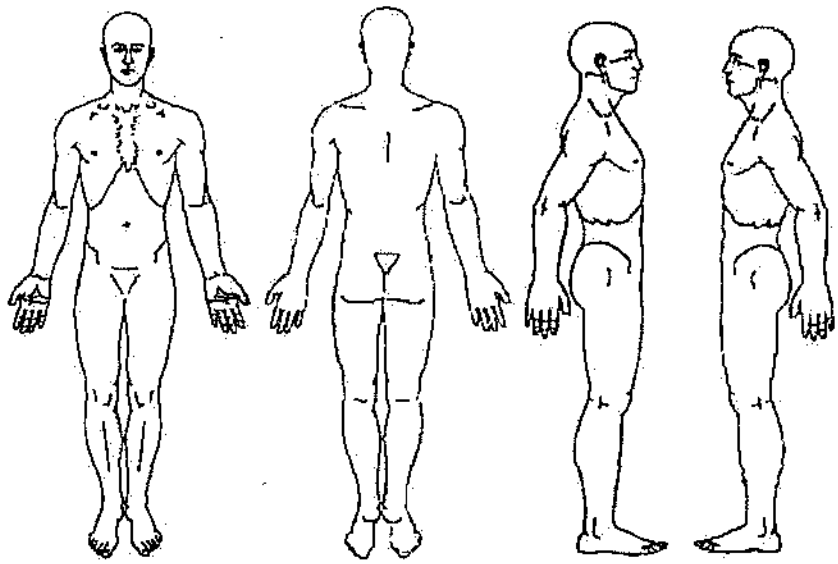
| | Diabetes | Heart Disease | Cancer | Stroke | Thyroid | Arthritis | Mental Illness | Auto Immune | Back/ Spine | High Blood Pressure | Osteoporosis | High cholesterol |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brother(s) # of: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sister(s) # of: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandmother (maternal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandfather (maternal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandmother (fraternal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandfather (fraternal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**SUBJECTIVE FINDINGS** *PAIN CLASSIFICATION*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CERVICAL: | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Sharp | ☐ Dull | ☐ Aching | ☐ Intermittent | ☐ Constant |
| THORACIC | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Sharp | ☐ Dull | ☐ Aching | ☐ Intermittent | ☐ Constant |
| LUMBAR: | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Sharp | ☐ Dull | ☐ Aching | ☐ Intermittent | ☐ Constant |
| PELVIC: | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Sharp | ☐ Dull | ☐ Aching | ☐ Intermittent | ☐ Constant |

VAS 1 2 3 4 5 6 7 8 9 10/10

## Areas of Discomfort or Problem



Use the above space to describe anything you need to communicate about the area of the chart you have marked.

**Please mark all areas on picture with an X where you are feeling pain or significant stress.**

What makes the practice of Dr. Newquist unique is the scope of his diagnostic training and excellence. Beginning with the preliminary consultation and health history, your health is our main concern. The history is reviewed by the nurse, technician and doctor. Test results and diagnostic imaging studies are reviewed. Then, a thorough physical examination testing bones, muscles, nerves, ligaments, tendons and other tissues related to your condition, is performed comfortably and non-invasively. Our commitment to patient education allows our patients to understand the nature of their problems and therefore get well faster. We are highly effective at communicating with patients as to their condition, needs, goals and concerns. We always make it a priority to give our patients the knowledge to help them take responsibility for their own health and prevent future problems.

Diagnosing the cause of your problem is our first priority. We believe there is no substitute for accuracy and preciseness in determining the cause of pain. Treatment differs dependent upon the diagnosis and therefore it is critical to know what generates the pain. If we are able to help you, then you will be accepted as a patient. If we are not able to help you, we will refer you (and make the appointment and arrangements) to the appropriate specialist (surgeon, rheumatologist, neurologist, pain management specialist, internist). It is our expressed policy to only accept those for care we truly believe we can help.

I declare that the information provided on this form is accurate and complete to the best of my recollection. I will inform the doctor if any other facts about my condition come to mind during the time I am in active care at this office.

Signed: _____

Date: _____

Witness: _____

6735 Cascade Rd., suite 200
Grand Rapids, MI 49546
(616) 464-1091 Telephone
(616) 325-1237 Fax

ChiroPros

# Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of phsio therapy, diagnostic x-rays, personal training and any supportive therapies on me (or the on the patient named below for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, personal training and procedures. I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic and/or personal training there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, soreness, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand Chiropractic adjustments, personal training and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health, including supportive methods involving soft tissues. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures and/or supportive measures offered by this office. These treatment options include, but not limited to self-administered over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

**I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

## Receipt & Authorization for information contained in Notice of Privacy Practices

By the way of my signature, I provide ChiroPros (Family First Chiropractic PC) with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment, healthcare information and healthcare operations as described in the Privacy Notice. I have received a copy of the Notice of Privacy Practices.

I authorize ChiroPros to contact me regarding appointments, financial reasons, healthcare related services and/or products, meetings, workshops, referrals and treatment matters by telephone, mail, electronically or other means on file. I authorize delivering of care in an open door and/or open concept environment and understand this is a chiropractic and physiotherapy office as described in the Notice of Privacy Practices. By signing this, I acknowledge the above and having been notified received a copy and understand the Notice of Privacy Practice for ChiroPros. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PRINTED Name of Patient: _____

SIGNATURE of Patient: _____ DATE: _____

Printed Name of Guardian (if minor or legal guardianship): _____ Relationship: _____

Signature of Guardian: _____ DATE: _____

Doctor of Chiropractic: Scott A. Newquist, D.C.

**ChiroPros**
6735 CASCADE RD., SUITE 200
GRAND RAPIDS, MI 49546

## *Financial Policies*

(616) 464-1091 TELEPHONE
(616) 325-1237 FAX

**Payment Guarantee:** For services rendered by ChiroPros, you guarantee payment of your account at the time services are provided for any and all costs not paid by an insurance carrier, government payer (including Medicaid), and other third party payer (together, referred to as "PAYER"), including in the event that if at a later date after initial approval your Payer denies your claim. You further understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that if your dependent is provided services you will be responsible for payment under these same policies, terms, and conditions.

**Assignment of Benefits:** To the extent there is third party coverage for payment of services, you agree that all medical and related benefits PAID by PAYER will be irrevocably assigned to ChiroPros on your behalf.

**Billing Information:** It is essential that you provide us with complete and accurate information so that we may properly submit billing information to your insurance company (i.e. home address, phone numbers). We will make every effort to submit claims to your insurance company and send you a statement. However, if for any reason the statement is returned to our office because of a problem with an address you provided, you may be dismissed in accordance with these policies, terms, and conditions and referred to a collection agency. To avoid this, please ensure that all of your information is accurate, and up-to-date. If you do not have your insurance card with you, you may be required to make payment in full that day.

**Medicare Agreement:** If you have Medicare coverage, you acknowledge that payment of benefits will be made to you or on your behalf for any services furnished to you by ChiroPros (or the party who accepts assignment), including your physician services. You authorize any holder of medical or other information about you to release to Medicare and its agents, any information needed to determine these benefits or any benefits for related services.

**Payment terms:** We require payment at the time of your office visit. If you fail to make payment at the time of service we may charge an extra processing fee in recognition of the expenses of preparing and sending out a Statement. Depending on your insurance policy benefits, this payment could be for a co-payment, coinsurance, deductible, or for the entire services rendered at that visit, non-covered services, prior authorization required, etc.

**Insurance Billing:** As your healthcare provider we will file your claims with your insurance company as a courtesy after services are provided, however, if you notify us not to file it with your Payer we will honor your request. It is your responsibility to understand what services are covered. If you have any questions whether a service will be covered, contact your insurance before the service is provided. The codes that are listed for services provided are based on American Medical Association guidelines. There are several factors involved when making the decision for the type of services to be billed. Among those factors are whether you are a new patient, the reason for the visit, the amount of time the service takes, and the complexity of the medical problem. Insurance companies make their payment decisions about medical services by looking at what your insurance policy provides. Example: If the reason for your visit is a massage and your insurance company does not cover that service we cannot go back and change the reason for your visit. It is your responsibility to find this out ahead of time. If services are not covered you will be fully responsible for them. You are responsible for payment until the account is paid in full by your insurance company. Once we have received an EOB from your insurance company indicating the amount you will be responsible for, a Statement for the balance will be sent to you and payment is expected by the due date contained on our statements.

**Interest and Attorney's Fees:** In the event that amounts due on account of services provided to you are not satisfied when due, ChiroPros shall be entitled to charge interest at the rate of 1.5% per month (18% per annum) and you shall be responsible for all costs and expenses incurred in efforts to collect any unpaid amounts due from you, including any interest charges due, court costs, collection agency fees, and all reasonable attorney's fees. Further, in the event that a check is returned for insufficient funds, all charges incurred by ChiroPros shall be your responsibility.

**Workers Compensation Injury:** If you believe you are being seen for an injury/illness as a result of your job, we must have written authorization from your employer to confirm this, and directions from your employer regarding who we should bill for this service. If we do not have this information at the time services are provided, we will bill you and/or your insurance company.

**Self Pay Services:** Self Pay patients require **payment be made in full at the time services are rendered** (and where no claim form is prepared or billing statement has to be mailed).

**Payment is YOUR responsibility:** Our relationship is with you. **All charges incurred are your responsibility**. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot depend on your insurance company to make timely payment on your behalf. We are not responsible for delays, misplaced claims, or the need for additional information from you by your insurance company.

**ChiroPlan Payment Options**: If you are unable to meet your financial obligation, payment arrangements can be made. This is called the ChiroPlan. This must be **signed and paid prior to services are rendered.**

**Making Payments:** Patients may pay by cash, money order, check or credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account," if you have these. One, or all, of these cards may be used to pay your bill, and may be kept on file by us to facilitate billing. Patients agree if they have a credit balance after paying for a service, ChiroPros can apply it to any outstanding balances on their account.

**Fees Assessed by ChiroPros:** You may be charged fees for the following: ***(1) Returned Checks (2) Completion of Forms*** (e.g. Disability or Family Medical Leave) ***(3) Copying of Medical Records (4) Failure to Cancel Appointment ("No Show")*** - if you do not advise us of your inability to keep your appointment prior to 24 hours before your appointment. The Fee for a No Show appointment may be assessed up to the amount in our current Fee Schedule.

**Termination of Services:** If you do not respond to 3 notices to the address we have on file, you agree that ChiroPros may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual provider/location.

**Authorization to Release of Medical Information:** You authorize the release of information by ChiroPros to third party payers, health care institutions, physicians and other providers involved in your medical care.

**Accidents and Motor Vehicle Injuries:** ChiroPros can decide whether or not to work with you through a third party payer to cover services rendered. In all cases you bear the responsibility for these costs and must pay them promptly at any time that location decides to bill you directly. You must not have had an Independent Medical Examination (IME) retained an attorney, the case cannot be litigation, and the case must be active. Proof of prior payments to providers within the last 30 days may be required. If an attorney has been retained and ChiroPros agrees to treat you, an Attorney Lien must be signed by all parties prior to any services rendered. **Continuing Agreement:** I have read this information carefully and agree that everything in this Agreement applies to current and future health care services provided by ChiroPros. I acknowledge that ChiroPros may change these terms without notice to me.

Printed Name: _____

Patient Signature: _____ Date: _____

**PATIENT NAME:** _____ **DATE:** _____
INSURANCE COMPANY: _____

ChiroPros
6735 Cascade Rd. Suite 200
Grand Rapids, MI 49546
(616) 464-1091 Tel.
(616) 325-1237 Fax

*Patient Acknowledgement of Financial Responsibility*
*Non-Covered Service(s) Form*

I hereby authorize, Family First Chiropractic, P.C. (dba ChiroPros), of Grand Rapids, MI to perform the following medical service (mark services), on date of service: ____/____/____:

____ adjustment $45
____ new patient exam $75-$120
____ return patient exam (over 1 year) $55-$85
____ other: _____

_____ massage $15 (per unit)
_____ exercise$31 (per unit)
_____ dry hydrotherapy $20 (per unit)

**FOR ALL MEDICAID PRODUCTS (NOT MEDICARE, USE A.B.N. FOR MEDICARE):**

_____ I understand this service(s) may not/is not covered by my healthcare benefits plan, regardless of the reason (not a covered service, not medically necessary, multiple services same day, maximum units, inclusive, etc.), I will be responsible for payment.
Estimated cost is listed above.

**XXXX** I understand this service(s) may not be covered by my insurance plan as my insurance policy effective date, benefits, deductible and copay/co-insurance has not been confirmed within the last 3 days and Medicaid policies may change monthly. Estimated Cost is listed above.

____ I understand the doctor and/or healthcare office does not participate with one, or both of my insurances. I also agree this form stays in effect throughout my treatment so long as the status of participation does not change and this form is inclusive of all future visits, thus not having to be signed each visit.
Primary ins.: _____, Participates: Yes / No
Secondary ins.: _____, Participates: Yes / No
Estimated Cost: is listed above.

____ I understand that I am responsible for the service(s) for reasons other than listed above. Please see note: _____.
Estimated Cost: is listed above.

**Patient Signature:** _____ **Date:** ____ / ____ / ____
*Failure to read, acknowledge, agree to and sign this form each visit may result in your appointment being rescheduled until verification of benefits is completed. Thank you for your understanding.

ChiroPros
Scott A. Newquist,D.C.

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Grand Rapids, MI 49546
Tel. (616) 464-1091
Fax (616) 325-1237

## Missed Appointments Policy

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time *just for you.* When appointments are missed or cancelled, your care and optimal result is delayed and that time is permanently lost, while other patients that have needed treatment are put off unnecessarily.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

If you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of twenty-four hours notice to us so we may schedule another patient in need of treatment.

It is our policy that with less than twenty-four hours notice on a change of commitment, a charge of $25.00 for Dr. Newquist, $50 for therapist appointments will be applied to your account.

If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

_____ Date:_____
Patient Signature

_____
Printed Patient Name