Welcome

Patient Information

Date_____
First Name_____
Last Name_____
Address_____
City_____
State_____ Zip_____
Email_____
Sex ___M ___F Marital status __M __D __S __W
Age_____ Birthdate_____
Occupation_____
Employer/School_____
Home Phone_____
Cell Phone_____
Work Phone_____
Best number/place to reach you_____
Spouses Name_____
Occupation_____
Employer_____
Children Names and Ages_____
_____

Primary Care Doctor_____
Number_____

In Case of Emergency, Contact:
Name_____
Phone_____

Have you been to a chiropractor before? ___Y ___N
Date of last visit_____
Name of D.C._____
Reason for leaving or discontinuing care:
_____

Accident Information
Is your condition due to an accident? ___Y ___N
Date_____
Have you been in a previous auto accident? ___Y ___N
Date_____
Have you made a report for this accident? ___Y ___N
To whom_____
Attorney Name _____
Attorney Number_____

Insurance Information

Health Insurance Name_____
Primary Insured_____
Relationship to Patient_____
Group #_____
Is there additional insurance? ___Y ___N
Subscriber's Name_____
Social Security #_____

Financial Responsibility

I understand that the insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Hoffmann Chiropractic and Wellness Group (HCWG), Inc, owner and operator of Napa Chiropractic and Integrative Health Center for any charges not covered by health care benefits. It is my responsibility to notify HCWG, Inc. of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determines by this office and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payments of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to Hoffmann Chiropractic and Wellness Group, Inc. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared by HCWG, Inc , and will constitute a continuing authorization, maintained on file with HCWG, Inc. which will authorize and allow for direct payment to HCWG, Inc., of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by HCWG, Inc.
The doctor on staff may use my health care information and may disclose such information to applicable insurance companies and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

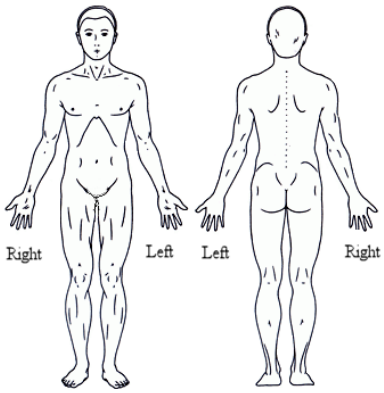
Patient Signature_____
Guardian Signature_____
Relationship to patient_____
Date_____

Napa Chiropractic and Integrative Health Center

Confidential Patient Case History

Please complete this questionnaire to the best of your ability. Your care will be largely based on the information you provide. This is confidential and will be a part of your permanent records. THANK YOU!

1. Indicate with an X on the drawings below where you have pain/symptoms.



List and briefly describe your symptoms in order of severity

1._____
2._____
3._____
4._____
5._____

On a scale of 0-10 (10 as the worst), how would you rate your top three problems:

0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10

2. Major condition that brought you in today_____
3. How long have you had this condition?_____
4. Have you had this or similar conditions in the past?_____
5. How do you think your problem began?_____
6. Place X by best description(s) of your pain: __Sharp __Tingly __Numb __Diffuse __Shooting __Stiff __Dull __Achy __Burning __Sharp with motion __Shooting with motion __Stabbing with motion
7. How often do you experience your symptoms? __Constantly __Frequently __Occasionally __Intermittently
8. Are your symptoms: Improved___ Unchanged___ Getting worse___
9. How much has the problem interfered with your work? __Not at all __A little bit __Moderately __Quite a bit
10. How much has the problem interfered with social activities? __Not at all __A little bit __Moderately __Quite a bit
11. Is this condition interfering with your: Sleep___ Daily Routine___ Other_____
13. Do any positions make it feel worse?_____
14. Do any positions make it feel better?_____
15. Activities or movements that are hard to perform?_____
16. Other doctors or therapists who have treated <u>THIS</u> condition_____
17. Have you had any x-rays or MRI's for this condition?_____ Date taken:_____
    Location_____ Phone Number of facility_____
18. Are you currently on any medications for this condition?_____
19. List all other medications you are currently taking_____
_____
20. List surgical operations and years:_____
_____
21.Other Hospitilizations: _____
_____

22. What of the following habits do you currently do?

Smoking___ # packs/day___ Alcohol___ #drinks/week___ Coffee/Caffeine___ #drinks/day___

23. Do you exercise? Yes___ No___ If so, how many times/week?_____

24. Do you sleep well? Yes___ No___ Do you wake rested? Yes___ No___

25. What activities do you do at work?

a. ___Sit __Most of day __Half the day __A little of the day

b. ___Stand __Most of day __Half the day __A little of the day

c. ___Computer Work __Most of day __Half the day __A little of the day

d. ___On the phone __Most of day __Half the day __A little of the day

26. What activities do you do outside of work?_____

27. How would you rate your overall health? __Excellent __Very Good __Good __Fair __Poor

28. Please mark any of the following conditions or symptoms that you have now or have experienced in the past:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

29. Are you currently under medical care for any condition?_____

30. For how long?_____

31. What side effects have you experienced from the drugs and surgery?_____

32. Females Only: Are you possibly Pregnant?_____

33. Do you have a family History of:

Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's side	O	O	O	O O
Mother's side	O	O	O	O O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Name_____

Patient Signature_____**Date**_____

Office Policies and Procedures

Patient Needs and Questions:
Your questions and concerns are important to us. Should any needs or questions arise, please ask for what you need or do not understand.

Office Policies:
The office staff will strive to meet your needs in a timely and efficient manner with open communication and prompt follow-up. All office policies will be explained as necessary and as questions arise. Your suggestions are welcomed. We wish to continually improve, self-evaluate, and keep our eyes on our quality of service.

Appointments:
Advanced appointments are required for massage and rehabilitation sessions. While we appreciate your making appointments in advance for chiropractic adjustments we are proud to offer a "no appointment necessary policy". You can always feel free to drop in for a chiropractic treatment any time during our regular business hours. If you have an appointment, and you are on time for that appointment, we will make sure to honor it to the best of our ability. Otherwise you will be seen in order of your arrival time. If you are on the schedule, please call us if you will not be able to make it and we can reschedule you for a better time. We will offer confirmation calls for those on the schedule.

X-Rays and Lab Tests:
X-rays and MRI's are typically not taken at the beginning of treatment unless it is deemed clinically necessary by your condition. Our office treatment does not rely on those tests. Such tests may be ordered if you are not responding to care, have had a trauma, or if a pathology or fracture is suspected.

Medical Records:
To have your medical records released to another health care practitioner, your authorization is required. A records release form must be completed and signed by you to enable us to release or obtain your records to/from another medical office. All records and x-rays are property of this office, and copies may be obtained. A small fee may be applied for copies and processing.

Financial Policy:
If you do not have insurance, all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time. Our care packages make care an affordable part of your family budget.
If you have health insurance, all deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100. You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimbursement is based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.
When your schedule of visits is on a maintenance only basis, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. You may continue to try to collect reimbursement for those services from your insurance company.

Fee Schedule:
We keep a current fee schedule posted in our sign in area at all times. Please ask about our acute care and wellness care packages. We will always do our best to keep our fee's reasonable and affordable.

Nutritional Supplements:
Supplements must be paid for at the time of service and are non-refundable if opened.

Notice of Information Practices and Confidentiality:
Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent.
Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.
In the future we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Please let us know if this is unacceptable to you.
You may file a complaint about privacy violations by contacting our office manager.

Informed Consent for Examination and Treatment:
I hereby consent to the performance of examination and treatment on me or on_____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic. I have had the opportunity to discuss with the doctor or other clinic personnel the nature and purpose of the different physiotherapy procedures and chiropractic manipulation. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based on facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest. I further understand that there are certain degrees of risk associated with chiropractic health care and physiotherapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive. I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. I am aware that the doctor will not be held responsible for any pre-existing medically diagnosed condition or medical diagnosis. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

I understand and agree that health and accident insurance policies are an agreement between my insurance carrier and myself. Should a check be mistakenly or purposefully be issued directly to me from my insurance company for services rendered by HCWG, this check will be signed over to HCWG or a new one for the same amount will be written within 7 days of receipt of the original check. I understand HCWG reserves the right to collect any monies due them for services rendered in this office. I understand that I am personally responsible for full payment of the account.
I agree to abide by the Policies and Procedures of this office and understand that such procedures are set in place to protect me and offer the best and most efficient care possible.

Patient Name_____ **Signature**_____ **Date**_____
Guardian_____ **Witness**_____ **Date**_____