# WELCOME

## PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

## PATIENT CONDITION

Reason for Visit _____

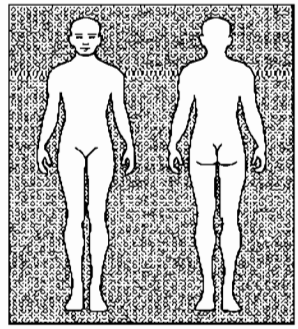
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

# HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Alcoholism | ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Measles | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Allergy Shots | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Migraine Headaches | ☐ Yes | ☐ No | Sexually Transmitted Disease | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Fractures | ☐ Yes | ☐ No | Miscarriage | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Anorexia | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Mononucleosis | ☐ Yes | ☐ No | Suicide Attempt | ☐ Yes | ☐ No |
| Appendicitis | ☐ Yes | ☐ No | Goiter | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Gonorrhea | ☐ Yes | ☐ No | Mumps | ☐ Yes | ☐ No | Tonsillitis | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Tumors, Growths | ☐ Yes | ☐ No |
| Breast Lump | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Parkinson's Disease | ☐ Yes | ☐ No | Typhoid Fever | ☐ Yes | ☐ No |
| Bronchitis | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No | Pinched Nerve | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Bulimia | ☐ Yes | ☐ No | Herniated Disk | ☐ Yes | ☐ No | Pneumonia | ☐ Yes | ☐ No | Vaginal Infections | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Herpes | ☐ Yes | ☐ No | Polio | ☐ Yes | ☐ No | Whooping Cough | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Prostate Problem | ☐ Yes | ☐ No | Other _____ | | |
| Chemical Dependency | ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No | | | |
| Chicken Pox | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| | | | | | | Rheumatoid Arthritis | ☐ Yes | ☐ No | | | |

## EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

## WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

## HABITS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## MEDICATIONS

Pharmacy Name _____

Pharmacy Phone (____) _____

## ALLERGIES

## VITAMINS/HERBS/MINERALS

16515 S. 40th St
Suite # 129
Phoenix, AZ 85048
Phone (480) 940-7444
Fax (480) 940-7454

# PATIENTS OF MOUNTAINSIDE WELLNESS CENTER, INC.

As our office continues to grow, we want to make sure we give our patients the best care that we can possible give. In order for us to do so, we are re-enforcing our policy here at Mountainside wellness in regards to scheduled appointments. Scheduled appointments are made in order to accomplish you getting well. There are times that we turn patients down due to a full schedule. If scheduled the patients do not show up, this leaves an open slot that could have been filled for a patient that was in need of treatment. If you cancel your appointment, it will delay your recovery and possibly someone else's. If you must miss it, it is best to reschedule as soon as possible as a courtesy to the Doctor and to other patients. We are implementing a **24 Hour Cancellation Policy**. We do understand that emergencies come up, and we will honor those. **If you are schedule for a massage with our therapist, a $15 cancellation charge will be billed to you.** We appreciate a call if you will late and we will do same for you should this unlikely event arise. Also, as a courtesy to others, please put all phones on silent.

**Our office hours are as follows;**
**Monday & Wednesday: 9am-1pm & 3pm-6:30pm**
**Tuesdays: Closed**
**Thursday: 3pm-6:30pm**
**Friday: 9am-1pm & 3pm-5pm**

The purpose of these policies is to allow us to serve you more completely and to get the best results from your visits. Our mission is to serve our patients and our community with long lasting care, providing quality service to each patient as each is a unique individual with specific health needs and wants. Furthermore, we strive to act as teachers, healers and health caretakers so we may be able to being the health benefits of chiropractic with the understanding and availability to all so they too may experience the true "living" and "health" that comes from having a healthy spine and nervous system.
Thank you for being great patients!

Patient Print_____

Patient Signature_____

Date_____

# *NOTICE OF PRIVACY PRACTICES*

*Effective April 14, 2003*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU *MAY* BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.**

At Mountainside Wellness Center, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.

This Notice describes the privacy practices of Mountainside Wellness Center. This Notice applies to all of the health records that identify you and the care you receive at Mountainside Wellness Center. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

**MOUNTAINSIDE WELLNESS CENTER:**

All of our doctor's and affiliated partners follow the terms of this Notice.

The doctors and other caregivers at Mountainside Wellness Center who are not employed by Mountainside Wellness Center exchange information about you as a patient with Mountainside Wellness Center. These health care practitioners may also give you other privacy notices that describe their office practices.

**HOW MOUNTAINSIDE WELLNESS CENTER MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:**

When you become a patient we will use your health information within Mountainside Wellness Center and disclose your health information outside Mountainside Wellness Center for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

**Treatment.** We use your health information to provide you with health care services. We may also disclose your health information to other doctors, therapists, or other persons associated with Mountainside Wellness Center who need that information to take care of you. For example, a doctor treating you in the ward may have helpful information to assist in returning you to full health. This may also involve talking to family members.

**Payment.** We may use and disclose your health information so that the health care you receive may be billed and paid for by you, your insurance company, or another third party. For example, we may give information about treatment plans you may have here to your health plan so it will pay us or reimburse you for the care.

**Contacting You.** We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. We may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

**Health-Related Services.** We may use and disclose health information about you to send you mailings about health-related products and services available at Mountainside Wellness Center.

**Legal Matters.** We will disclose health information about you outside Mountainside Wellness Center when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

**AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES:**

As described above, we will use your health information and disclose it outside Mountainside Wellness Center for treatment, payment, health care operations, and when permitted or required by law. We will not use or disclose your health information for *other* reasons without your written authorization. For example, you may want us to release medical information to your employer or to your child's school. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

**YOUR RIGHTS REGARDING HEALTH INFORMATION:**

**Right to Accounting.** You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Mountainside Wellness Center has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the name of the facility that maintains the records about which you want the accounting. We will not list disclosures made before April 14, 2003, or those made earlier than 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the medical records department of the CCHS hospital or facility that maintains the records or to the Privacy Office, The Cleveland Clinic Foundation, Cleveland, Ohio 44195. We will respond to you within 60 days. We will give you the first listing within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

**Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend.

**Right to Inspect and Obtain Copy.** You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding or certain research records while the research is ongoing. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated. We may charge a fee for processing your request.

**Right to Request Restrictions.** You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated. The request should also describe the information you want restricted, say whether you want to limit the *use* or the *disclosure* of the information or both, and tell us who should not receive the restricted information. You must submit your request in writing. We will tell you if we agree with your request or not. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

## COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with mountainside wellness center or with the secretary of the U.S. Department of health and human services. To file a complaint with Mountainside wellness, you must submit your complaint in writing.

If you have questions about this notice, you may telephone the number shown below for Mountainside Wellness Center and ask for the privacy official.

**Mountainside Wellness Center**
**16515 S 40th St**
**Suite 129**
**Phoenix, Arizona 85048**
**(480)940-7444**

Date_____

Patient Print_____

Patient Signature _____

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic X-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, 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 discus with the doctor of chiropractic named below and-or with other office or clinic personnel the nature and purpose of chiropractic adjustments 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 there are some ricks to treatment including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, it is my best interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improve health. 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 used, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest; steroid injections; bracing; and surgery. I understand that I have been informed that I have the right to a second opinion and secure other opinions If I have concerns as to the nature of my symptoms and treatments options.

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

Patient Print_____

Patient Signature_____

Print Guardian/Parental and relationship to patient_____

Guardian/Parental Signature_____

Date_____

Doctor of Chiropractor name_____

Doctor Signature_____

Date_____