Health Solution Centers

Chiropractic & Physical Therapy

Welcome to Health Solution Centers! Please fill out the following information to the best of your knowledge. If you have questions, please inform the front desk and they will be happy to assist you.

First Name:_____ **MI:**_____ **Last:**_____

Social Security Number:_____ **Date of Birth:**_____ **Age:**_____

Gender: M / F Home Phone: ( )_____ **Cell Phone: ( )**_____

Would you like appointment reminders by text? Y / N

If yes, please state your cell phone provider (EX:Verizon)_____

Email Address (to view medical records online):_____@_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Marital Status: S M W D Spouses Name:_____

Children's Names and Ages:_____

Employer Name:_____ **Job Title:**_____

Work Phone: ( )_____ **Work Address:**_____

Insurance Carrier:_____ **Primary Insured Name:**_____

Primary Insured DOB:_____

Emergency Contact:_____ **Phone Number: ( )**_____

Family Physician:_____ **Phone Number: ( )**_____

Is this is work related injury? Y / N Is this a personal injury case? Y / N

How did you hear about Health Solution Centers?_____

If by person, please state name:_____

I,_____; the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to the clinic staff providing me with verbal descriptions, when there are changes to my exams and treatments, consent to the clinic staff providing said treatments and exams and hereby consent to any similar subsequent treatments and exams. If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my treatment or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform clinic staff.

Patient Signature:_____ **Date:**_____

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HIPPA DECLARATION

Our Practice:

A) Is required by federal law to maintain the privacy of your personal health information (PHI) and to provide you with this privacy notice detailing our practice's legal duties and privacy practices with respect to your PHI.
B) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which provided for under federal law
C) Is required to abide by the terms of the Privacy Notice
D) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
E) Will distribute any revised Privacy Notice to you prior to implementation
F) Will not retaliate against you for filing a complaint

Patient Communications:

Health Insurance Privacy Act 1996 requires we inform you of the following government stipulations in order for us to contact you with educational and promotional items in the future via email, US mail, telephone, and/or pre-recorded messages. We WILL NOT ever share, sell or "spam" your personal contact information.

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. Communication can be defined as Voice Blasts, Email, and numerous marketing pieces. Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication.

A) Communications about participating providers in a provider or health plan network, replacement of or enhancements, to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefit plan.
B) Communication for treatment of the individual.
C) Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care setting to individuals.

PATIENT ACKNOWLEDGEMENT

I acknowledge receipt of this notice, and my understanding and my agreement is to its terms.

Patient Signature: _____ Date: _____

Office Use Only:

☐ Patient refused to sign

☐ Patient unable to sign for the following reason: _____

HEALTH SOLUTION CENTERS
FINANCIAL AGREEMENT

Please remember that health insurance in considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, and any other balance not paid by your insurance company.

In order to manage your account balance, it is our policy to collect co-pays, co-insurance, and deductible amount at the time of service.

If this account is assigned to an attorney or outside agency for collection, Health Solution Centers shall be entitles to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

Patient Signature **Date**

Legal assignment of benefits and release of medical and plan documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance/employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Health Solution Centers all medical benefit/ insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy/ settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance/ employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies / employee health care plan: any claim, chose in action, or other right I may have to such insurance /or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and such clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including if necessary bring suit with such doctor and clinic against such insurers and/ or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian **Date**

Health Solution Centers

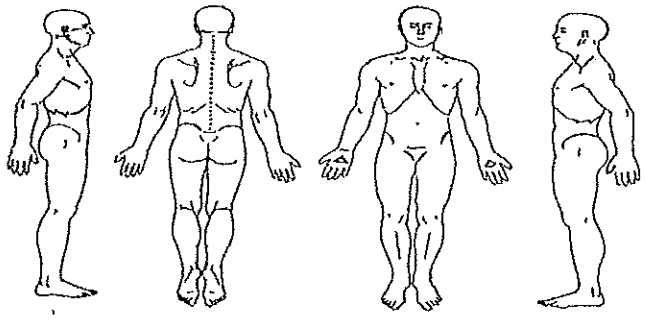
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-Morning -Increase during the day

-Afternoon -Same all day

-Night -Decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Getting Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping – Other:
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago/By Whom? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Do have a **pacemaker** ___ No ___ Yes If female: Are you **pregnant**? ___ No ___ Yes

_____ Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

Doctor Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ **by** _____ _____ D.C., and/or other licensed doctors of chiropractic who may be employed by or engaged in practice in the _____ Clinic.

I have had an opportunity to discuss with _____,D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

Date: _____

_____
Patient Name

_____
Patient Signature

_____
Relationship or authority
if not signed by Patient

DOCTOR'S NOTES

Patient counseled by the use of the following:

_____ Discussion

_____ Other (please specify)

X_____
Signature of Doctor or Other

Health Solution Centers

Chiropractic & Physical Therapy

Name: _____

Email Address: _____

Pharmacy Name and Location: _____

Medications Currently Taken:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies:

_____ _____

Tobacco Usage:

_____ Never Smoked

_____ Former Smoker

_____ Occasionally Smoke

_____ Every day Smoker