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 _____

Mark box "Yes" or "No" to indicate if you have had any of the following:

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

Please mark in each column which boxes best describe your activities:

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 (____) _____

Pharmacy E-mail (____) _____

Allergies

_____

_____

_____

Vitamins/Herbs/Minerals

_____

_____

_____

_____

_____

Chiropractic Registration and History

Patient Information

Date _____

Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex: ☐ M ☐ F Age _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

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 _____

Birth Date _____ 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 (_____)_____ Alt. Phone (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____)_____ Alt. 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 to the right 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) _____

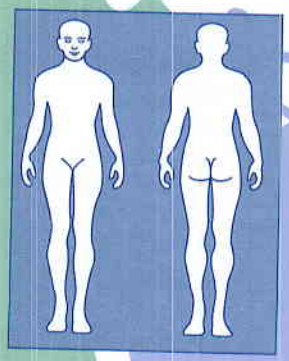
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



(Vers.C2SSS04)

– OVER –

DOCTOR-PATIENT RELATIONSHIP

INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors procedures often depend on environment, underlying causes and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such vertebral subluxation complexes are found, chiropractic adjustments and ancillary procedures may be given in attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedure are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, conditions, which do not respond to chiropractic, care, may come under control or be helped through drugs or surgery. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read and understand the foregoing.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that ***Bronco Injury & Chiropractic Center, PLLC*** "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review ***Bronco Injury & Chiropractic Center, PLLC*** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations with ***Bronco Injury & Chiropractic Center, PLLC***. It describes my rights as they concern the limited use of health information including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for ***Bronco Injury & Chiropractic Center, PLLC*** is also provided on request at the main administration desk of the practice.

Bronco Injury & Chiropractic Center, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient of Personal Representative

_____ _____

Description of Personal Representative's Authority

Patient Financial Responsibility Policy

*At **Bronco Injury & Chiropractic Center, PLLC** our goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.*

General

a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, **all charges regardless of the insurance coverage are the patient's responsibility** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, ***Bronco Injury & Chiropractic Center, PLLC*** bills the patient's insurance and makes every effort to ensure that claims are promptly and correctly processed. ***Bronco Injury & Chiropractic Center, PLLC*** also bills patient's secondary insurance when patients provide complete insurance information.

b. Patient co-pays are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first bill from ***Bronco Injury & Chiropractic Center, PLLC***. We accept cash, checks, money orders. If you can't pay your balance within 30 days, please contact us at P: ***(24[illegible]) 644-6272***. There are several ways you can pay your bill, including possible payment plans, and an Insurance Department representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.

Waiver of Co-Pays and Deductibles

a. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. ***Bronco Injury & Chiropractic Center, PLLC*** will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare*.

b. If ***Bronco Injury & Chiropractic Center, PLLC*** does waive co-payments or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. ***Bronco Injury & Chiropractic Center, PLLC*** will maintain records of what collection efforts have been made for fees waived in these instances.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of patient or Personal Representative

_____ _____

Description of personal representative's Authority

CHIROPRACTOR LIEN AND RELEASE OF RECORDS

TO _____ RE: _____ _____

_____

_____

I do hereby authorize ***Bronco Injury & Chiropractic Center, PLLC*** to furnish you, my attorney, with a full report of the examination, treatment, prognosis, etc., of myself in regards to the accident in which I was involved, occurring on or about _____. I hereby give a lien to ***Bronco Injury & Chiropractic Center, PLLC***, on any settlement, claim, judgment or verdict as a result of said accident, and authorize and instruct you, my attorney, to pay directly to ***Bronco Injury & Chiropractic Center, PLLC*** such sums from such settlement, claim judgment or verdict as may be necessary to protect ***Bronco Injury & Chiropractic Center, PLLC*** adequately.

I understand that I am directly and fully responsible to ***Bronco Injury & Chiropractic Center, PLLC*** for all medical bills submitted by ***Bronco Injury & Chiropractic Center, PLLC*** for services rendered to me and this agreement is made solely for ***Bronco Injury & Chiropractic Center, PLLC*** additional protection and in consideration awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said charges for treatment.

_____ _____ _____

Patient Signature Date

I undersigned, being attorney of record for the above patient, do hereby acknowledge receipt of the above lien and do agree to honor the same to protect adequately ***Bronco Injury & Chiropractic Center, PLLC***

_____ _____ _____

Attorney Signature Date

NOTE: Please sign, date and return the original document to ***Bronco Injury & Chiropractic Center, PLLC***

HIPAA AUTHORIZATION/RELEASE OF RECORDS/TRANSFER REQUEST

TO: _____

_____

I, _____, hereby authorize/request the release of my protected health information, (PHI) i.e., all medical records including but not limited to diagnosis, records of treatment, examinations, x-rays, specialists seen, and disability dates (if applicable) to:

Bronco Injury & Chiropractic

24777 Greenfield Road, Suite 201

Southfield, MI 48075

I understand that I may inspect or copy the PHI described by this authorization. I understand that, at any time, this authorization may be revoked by me, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Signature: _____

Patient Date of Birth: _____

Today's Date: _____