Stewart Chiropractic & Family Wellness Centre, Chad Stewart, DC

5045 W. Baseline Rd #120 Laveen, AZ 85339
4616 N. 51st Ave # 212 Phoenix, AZ 85031

Name: _____ Age: _____ Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____ Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____ Work Phone (_____) _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ **Relationship:** _____ **Phone (_____)** _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms better? _____ What makes your symptoms worse? _____

What is the quality of your symptoms? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Please list all medications and dosage:	**Frequency**	**For What Illness?**

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

Please list any recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

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Patient's Name: _____ Date: _____

Date of Accident: _____ Hour: _____AM _____PM _____

Specific Location of Accident: _____

Describe in detail, in your own words, how the accident happened: _____

_____

_____

In the accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Did your car strike the other vehicle? ☐Yes ☐No **Did the other car strike your car? ☐Yes ☐No**

Were you struck from: ☐ Behind ☐ Front ☐ Side Impact ☐ Driver's Side ☐ Passenger's Side

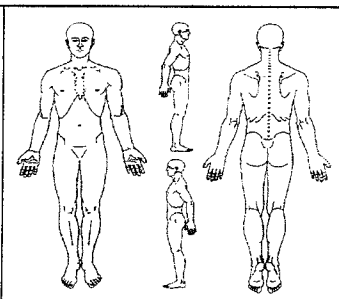
Were traffic citations issued to: ☐ You ☐ the Driver of Your Car ☐ the Driver of the Other Car ☐ No Citations Given

Was your car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS = spasms
DP = dull pain
SH = shooting pain
NU = numbness
ST = stiffness
SP = sharp pain
TI = tingling
O = Other



CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ Ears Ring
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ Buzzing in Ears
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ Dizziness
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ Depression	☐ Blurred Vision	☐ Tingling in Arms	☐ Loss of Taste
☐ Anxiety	☐ Sensitivity to Light	☐ Jaw Pain	☐ Any Burns
☐ Fainting	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ Any Stitches
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ Any Cuts

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Employer: _____ Employers Telephone: _____

Did you go to the hospital? ☐ Yes ☐ No: If Yes, Name of Hospital or E.R: _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

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Patient's Name: _____ Date: _____

PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

☐ I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
☐ I have group health insurance benefits either directly or through my spouse or parents.
☐ **I have retained an attorney.**
☐ **I have not retained an attorney.**
☐ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone:(_____) _____ Insured: _____

Claim #: _____ Policy #: _____

Telephone: (_____) _____ Fax: (_____) _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (_____) _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (_____) _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) Attorney: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Stewart Chiropractic & Family Wellness Centre is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

Staff Initials: _____

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602-237-1105 (P) 602-237-1106 (F)

Informed Consent

The nature of the chiropractic manipulation: I will use either my hands an instrument or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: Ice, Moist Heat Packs, Electrical Muscle Stimulation, Stretching/Strengthening Exercises, Massage/Manual Therapy, Neuromuscular Re-education and Mechanical Traction

Risks involved with the recommended ancillary treatments: Ice, Moist Heat Packs and Electrical Muscle Stimulation (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Mechanical Traction can cause temporary post-treatment soreness or reflex muscle spasms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name_____ **Date**_____

Patient Signature_____ **Dr.**_____

The patient had the following questions and was supplied the following answers:

_____

_____

It is my clinical opinion this patient is oriented to time and space: Yes No

It is my clinical opinion this patient was able to understand the language involved: Yes No

Patient & Doctor Agreement

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare all necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as the doctor deems appropriate through adjusting my spinal column. I understand and agree that the amount paid the doctor x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen by me at any time while I am a patient of this office. I also agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any existing medically diagnosed conditions, nor for any medical diagnosis.

Patient/Guardian Signature:

X_____ **Date:** _____

RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL _____

ADDRESS _____

_____

_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

_____ _____
If Patient Is A Minor Signature Of Parent Or Legal Guardian Relationship to Patient

_____ _____
Witness To The Above Signatures Please Print Name

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **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 or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have 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 or care may be terminated. Our payment plans make care an affordable part of your family budget.

   You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

   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 reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (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 once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

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 a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.