APPLIED CHIROPRACTIC HEALTH CENTER

DR. THOMAS A. FOOTE DC, FIACA

PLEASE READ:

Please tell Dr. Foote everything you want him to know concerning your symptoms, history, expectations of care and type of specific treatment you desire, even if you told his staff.

Dr. Foote will develop a spinal/musculoskeletal rehabilitation program for your specific problem, which may include manipulation but is not dependent on manipulation alone. Dr. Foote will give you a general idea about how long it will take and how many visits it will take for your body to heal. If you have questions please ask him.

Dr. Foote will review the treatment plan with you and then ask you to sign an informed consent statement if you want to proceed with treatment. If you would like to delay treatment to go over the treatment plan at home and make your decisions please let Dr. Foote know and no treatment will be performed today. We have a set first visit fee so you know, up front, what the examination, plan development and any needed treatment will cost. If you decide not to have treatment today the fee is still the same.

As a courtesy to Dr. Foote, **please** turn off your cell phone while you're in the treatment rooms. Thank you.

NOTES:

Dr. Foote will be giving you a lot of information that may be unfamiliar to you. Please use the space below to make notes to help your memory. You may need to write down nutritional advise, activity restrictions and specific exercises. You will be given a copy of your informed consent, general instructions and treatment plan so you don't need to keep notes on that information.

Medical History Form

Name: _____ Age: _____ Date: _____

Individual Medical History

Please place an X in all that apply.

Spinal Health	Self
Headaches	
Neck Pain	
Arm Numb/Tingling	
Shoulder Pain	
Upper Back Pain	
Rib Pain	
Lower Back Pain	
Leg Numb/Tingling	
Sacroiliac Pain	
Hip Pain	
Disc Injury	
Arthritis (RA or OA)	
Osteoporosis	
Muscle cramps	
Internal Disorders	
Cancer	
Sinus/Allergy	
Asthma	
Digestive Trouble	
Thyroid Problems	
Heart Problems	
Diabetes	
Stroke	
Gall Bladder Problems	
Kidney Disease	
Pacemaker	
Gout	
High Blood Pressure	

Family Health History

At times, health problems run in families. Please help us by placing an X in all that apply.

Spinal Health	Spouse	Father	Mother	Brother/Sister
Headaches				
Neck Pain				
Arm Numb/Tingling				
Shoulder Pain				
Upper Back Pain				
Rib Pain				
Lower Back Pain				
Leg Numb/Tingling				
Sacroiliac Pain				
Hip Pain				
Disc Injury				
Arthritis (RA or OA)				
Osteoporosis				
Muscle cramps				
Internal Disorders				
Cancer				
Sinus/Allergy				
Asthma				
Digestive Trouble				
Thyroid Problems				
Heart Problems				
Diabetes				
Stroke				
Gall Bladder Disease				
Kidney Disease				
Pacemaker				
Gout				
High Blood Pressure				

Social History

Activity	**Never**	**Occasionally**	**Moderately**	**Heavily**
Exercise				
Alcohol				
Smoking				
Lifting at Work				

Surgical History

Procedure	**Date**	**Procedure**	**Date**

CONFIDENTIAL PATIENT INFORMATION

Welcome to our office. If this is your first visit to a Chiropractic office you will find that it is much like any doctor's office. We are here to serve you and are aware that your time is valuable. Your first visit will take between 45 and 60 minutes. We encourage you to ask questions during your visit. The more you understand your condition, the more you can take an informed and active part in your recovery.

PATIENT DATA

Today's Date _____

Legal Name _____ ____ _____ Common Name _____

Street _____ Cell Phone (____)_____

City _____State _____Zip _____

S.S.# _____-_____-_____ Date Of Birth _____ Home Phone (____)_____

Marital Status _____Spouses Name _____

Occupation _____Employer _____Work Phone (____)_____

E-Mail address _____

INSURANCE INFORMATION

Please present your insurance card.

MEDICAL DATA

MEDICATIONS	VITAMINS / MINERALS	ALLERGIES

PAIN AND SYMPTOM INFORMATION

Please list your complaints in order of importance.

1 _____

2 _____

3 _____

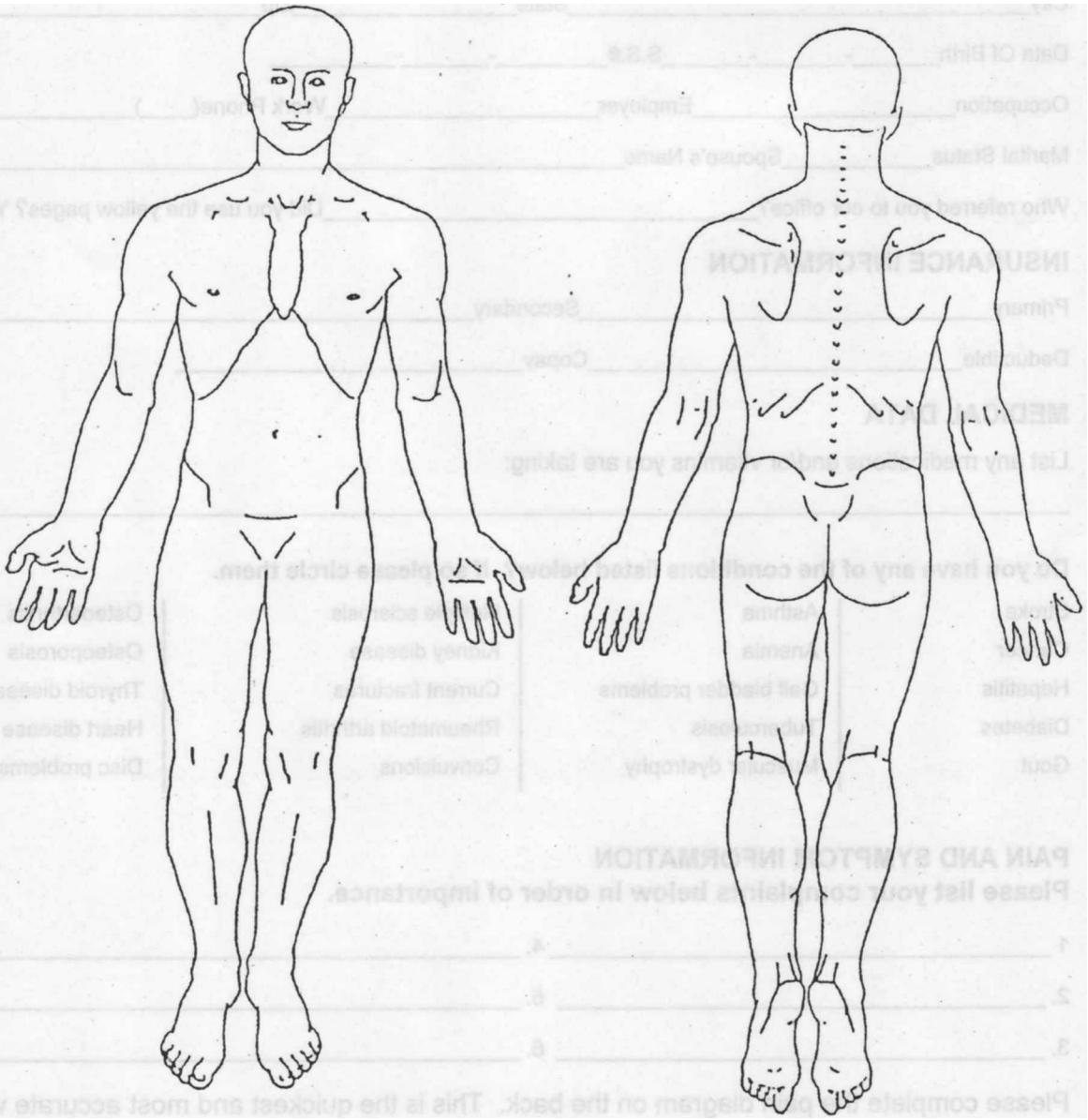
PAIN DIAGRAM

Please complete the pain diagram on the back. This is the quickest and most accurate way of listing your problems. It's important that you understand how to fill out the pain diagram correctly. If you have not completed one before or have any questions, please have the office staff help you.

PAIN DIAGRAM

Please outline the areas on the pictures below that correspond to areas of your body where you feel the sensations. Areas may overlap. Use the appropriate letters and an arrow to label the outlined areas.

S=SHARP PAIN **A**=ACHING **T**=TIGHTNESS **N**=NUMBNESS **P**=PINS AND NEEDLES **B**=BURNING



FINANCIAL POLICY

Our Mission: We strive to provide the best quality service at the most affordable fees. We will make it as easy as possible for you to receive the care you need.

Payment Policies: Payment for services is due at the time services are rendered unless prior arrangements have been approved by our staff. We accept cash, personal checks, MasterCard, Visa, Discover, and American Express.

First Visit Fees: We realize that when you come to the Applied Chiropractic Health Center for the first time you have a lot on your mind. In order to simplify your first visit we have decided to charge a flat fee for the first visit. This means that no matter what service are recommended and administer today they will be included in a flat fee of $75. Services may include consultation, examination, manipulative therapy, acupuncture therapy, meridian mapping, electrical therapy, ultrasound, exercise training, spot massage and trigger point therapy. Any treatment not received on the first visit cannot be carried forward to another. Services that are not covered include vitamins, orthotics, braces and massage.

Insurance Policies: Your insurance is a contract between you and your carrier. You will be required to pay your treatment costs until your insurance coverage is confirmed. You will be responsible for any deductible, co-pay and non-covered services. If your insurance does not cover Chiropractic care, you will be responsible for the entire amount. Telephone verification by our staff may take up to an hour, depending on your insurance company and in some cases may not be possible due to HIPAA regulations. If you would like to know whether you are covered for these services, it is suggested that you check your policy or call your insurance company directly for verification.

Insurance Claim Submission: Insurance claim submission is becoming more complex and we work to stay current on all the variations of different companies. If you would like us to submit your claim as a courtesy to you, please **initial** here _____. In the event that your insurance company denies your benefit you will be responsible for your bill. If your insurance claim becomes over 90 days old, we will contact you for payment and you may continue to work with your insurance company toward payment. Some companies are worse than others.

Missed Appointments: Missed appointments are a burden to all businesses and ours is no exception. When you fail to call ahead of time to cancel your appointment, we cannot schedule another patient from our waiting list for that time. This is unfair to us and to our other patients.

Delinquent Accounts: Returned checks and non payment of greater than 60 days may be subject to additional collection fees and interest charges of 1 1/2% per month. We cannot continue to extend credit on any account that is over 60 days without payment. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We are here to help you.

Please sign below that you understand these policies.

_____ _____

Responsible Party Date

RELEASE OF INFORMATION/ ASSIGNMENT OF BENEFITS TO INSURANCE

RELEASE OF INFORMATION:
By signing this form, you are granting consent for the Applied Chiropractic Health Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our **Notice of Privacy Practices** provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our **Notice of Privacy Practices** before you sign the consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at **970-242-0808**. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not by law required to grant your request. However, if we do grant your request, we are bound by our agreement.

_____
Print Name

_____ _____
Signature Date

ASSIGNMENT OF BENEFITS:
I hereby authorize insurance payments to be paid to Dr. Thomas A. Foote for professional services rendered.

_____ _____
Signature Date