Welcome to Health Solutions!

We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Date: ____/____/_____ **Social Security #** _____-_____-_____

Sex: ☐Male ☐Female **Age:** _____ **Date of Birth:** ____/____/_____ **Pregnant** ☐Yes ☐No

Last Name: _____ **First Name:** _____ **M.I.** ___

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-Mail: _____

Cell Phone: _____ **Home Phone:** _____

Preferred Method of Communication: ☐Email ☐Text

Patient Employer/ School: _____

Address: _____

Phone: _____ **Occupation:** _____

☐Married ☐Separated ☐Widowed ☐Divorced ☐Single ☐Partnered for ____ yrs ☐Minor

Emergency Contact/Spouse: _____ **Relationship:** _____ **#:** _____

Height: _____ **Weight** _____ **Blood Pressure** ____/_____ **Pulse** _____

Accident Information: Is the condition due to an accident? ☐Yes ☐No

Date of Accident: ____/____/_____ **Type of Accident:** ☐Auto ☐Work ☐Home ☐Other _____

Who is your Family Physician or Primary Doctor that monitors you?

_____ **Phone Number:** _____

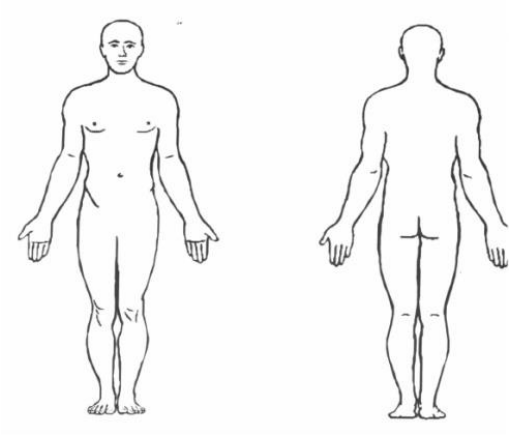
Please indicate the complaints you are seeing us for today: _____
_____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XX **Dull/Achy**

// **Sharp/Stabbing**

-- **Burning**



oo **Numb/Tingle**

ss **Stiff/Tight**

..**Pins/Needles**

When was the initial start date of this complaint? _____

Sitting here today what is the intensity of your pain on a scale of 0 to 10?

0 1 2 3 4 5 6 7 8 9 10

What caused this condition? _____

How often do you experience your pain? ☐Constant ☐Frequent ☐Occasional ☐Intermittent

Is there any radiating Pain into the arms/legs? ☐Yes ☐No **Is there any numbness/tingling?** ☐Yes ☐No

Has your condition ☐Improved ☐Stayed the same ☐Worsened

Is the problem relieved by ☐Chiropractic ☐Ice ☐Heat ☐Massage ☐Nothing ☐OTC Med. ☐Rest

Is the problem aggravated by ☐Bending ☐Computer ☐Sneeze/Cough ☐Driving ☐Lifting ☐Reaching ☐Sleeping ☐Standing ☐Sitting ☐Telephone ☐Twisting ☐Walking ☐Work

Have you had this complaint before? ☐Yes ☐No **If yes, explain**_____

What have you tried for this complaint? ☐Anti-Inflammatory ☐Chiropractic ☐Exercise ☐Injections ☐Pain Meds ☐Massage ☐Muscle Relaxers ☐Physical Therapy ☐Other _____

What Tests have you already had for this problem? ☐X-Ray ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV ☐Other: _____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

Systems Review

Please Check All That Apply:

Musculoskeletal: ☐ Implants, pins, screws ☐Arthritis ☐Arm/Foot Pain ☐Fracture ☐Knee Injury ☐Osteoporosis ☐Scoliosis ☐TMJ

Neurological: ☐Anxiety ☐Depression ☐ Seizures ☐Sleep Issues ☐Stroke

Head and ENT: ☐Ear/ hearing Problems ☐Earache ☐glasses/contacts ☐glaucoma ☐headaches ☐sinus trouble ☐sore throat

Cardiovascular: ☐Blood Clot ☐Heart Attack ☐Heart Murmur ☐High Cholesterol

Respiratory: ☐Asthma ☐Emphysema ☐Cough ☐Pneumonia ☐Snoring

Gastrointestinal: ☐Stomach Pain ☐Colon Cancer ☐Food Allergies ☐Heartburn ☐Ulcer

Genitourinary: ☐Kidney Stones ☐Sexual Dysfunction ☐Urinary Infections

Endocrine: ☐Diabetes ☐Steroid Tx ☐Testosterone Deficiency ☐Thyroid Problems

Dermatological: ☐Eczema ☐Acne ☐Psoriasis ☐Skin Cancer ☐Skin Trouble/Rashes

Past Medical History

Surgeries: ☐None Reported ☐Yes **If yes, please list:** _____

_____

Medications: ☐None Reported ☐Yes **If yes, please list:** _____

_____

Allergies: ☐None Reported ☐Yes **If yes, please list:** _____

Illnesses: ☐None Reported ☐Yes **If yes, please list:** _____

Major Accidents: ☐None Reported ☐Yes **If yes, please list:** _____

Social History

Work Habits: Hours worked: _____ ☐Standing ☐Sitting **Hours of Sleep:** _____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

Do you Smoke? ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

Exercise: ☐Never ☐Daily ☐Few times a week ☐Once a week

Diet: ☐Restricted ☐Not Restricted **How many meals a day?** _____

Authorization for care of a minor: I hereby authorize this office and its Doctors to administer care to my child as they deem necessary, I clearly understand and agree I am personally responsible for payment of all fees charged by this office. All signatures will be signed by a PARENT/GUAREDIAN if a minor is being treated.
All of the following will be signed by **Parent/Guardian Name: _____Parent/Guardian Initials_____**

CHIROPRACTIC INFORMED CONSENT TO TREAT AT HEALTH SOLUTIONS CHIROPRACTIC

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Wesley Wooden and/or Dr. Mark Wheeler and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors, including those who work at Health Solutions or any other office or clinic, whether signatories to this form or not. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, 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, and is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____

Signature: _____ **Date:** _____

CONSENT TO USE PHI/HIPPA DECLARATION AT HEALTH SOLUTIONS CHIROPRACTIC

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Health Solutions Chiropractic, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. This includes any pertinent documentation required for insurance.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I understand I may receive a copy of Notice of Patient Privacy Policy upon request.

X **_____Initials**

Requesting a Restriction on the Use or Disclosure of Your Information:

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of your Protected Health Information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

The office has open area treatment rooms. Exam rooms are available upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. ***By my signature below I give my permission to use and disclose my health information.***

Patient Name: _____ **Time:** _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Health Solutions Chiropractic Financial Policy

We strive to provide you the highest quality health care, while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience some out of pocket expense.

Our office does participate with many insurance plans. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. The amount they pay varies from one policy to another. We call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles, co-pays and co-insurance amounts.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES AT THE TIME OF SERVICE. IF YOU ARE A CASH PATIENT, PAYMENT IS ALSO DUE AT THE TIME SERVICE IS RENDERED.

A finance charge of 1 ½ % per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay a collection fee of up to 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.

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

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 and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Health Solutions Chiropractic, LLC all medical benefits and/or 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 benefit payments. I hereby authorize the doctor to release all medical information necessary to process the claim. 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 and/or 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 and/or employee health benefits claim submissions.

I hereby convey to the above named office to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefit coverage under any applicable insurance policies and /or employee health care plan with respect to medical expenses incurred as a result of medical services I received from the above named office 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 office in any attempts by such office to pursue such claim, chose to action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such office against such insurers and/or employee health care plan in my name but at such office expenses.

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

By signing below, I agree to Health Solutions Chiropractic, LLC Financial Policy and Legal Assignment of Benefits and Release of Medical and Plan Documents.

Patient Name:_____

Signature X_____Date:_____

Massage Therapy: Some insurance companies do offer benefits for massage therapy. Our office will submit the massage therapy charges to your insurance carrier at your request, however, if charges are denied for any reason, payment to Health Solutions Chiropractic will be your responsibility.

Patient Name:_____

Signature X_____Date:_____