Whom may we thank for referring you to this office? → ______________________________________

Maximize Chiropractic - ADULT HEALTH HISTORY FORM

Today's Date: ___________________ HR#: _____________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: ______-______-______ Age: __________ ☐ Male ☐ Female

Address: _______________________________________ City: ________________________________ State: _____ Zip: ____________

E-mail Address: ___________________________________ Home Phone: _______________________Mobile Phone:_______________

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _________________________________

Social Security #: ___________________________________ Driver's License #: ____

Employer: _______________________________________ Occupation: ____

Spouse's Name:_______________________________________ Spouse's Employer:____

Number of children and Ages: ____

Name & Number of Emergency Contact: ______________________ ___________________Relationship: ___________________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: ____

Secondarily: __________________________ Third: _____________________________ Fourth: ___________________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

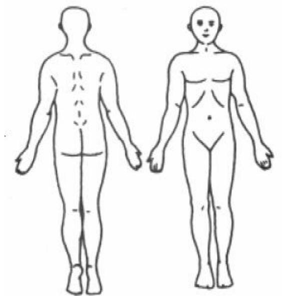
When did the problem(s) begin? ____________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?____________

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: ______ by whom? ________________________________

How long were you under care: ____________ What were the results? ____

Name of Previous Chiropractor: _______________________________ **☐ N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/ **S**tabbing **T**= **T**ingling

What relieves your symptoms? ____________________________

What makes them feel worse? _________________________________

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
___________________________________:	______________________________	______________________________
___________________________________:	______________________________	______________________________
___________________________________:	______________________________	______________________________

Is your problem the result of ANY type of motor vehicle accident? ☐ Yes, ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:____________________________________

____

HISTORY of COMPLAINT

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? __________ When was the last episode? _____________________ How did the injury happen?____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: __________________________________, and who provided it: _________________________ How long ago? _______________What were the results. ☐ Favorable ☐ Unfavorable→ please explain: ____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for *Never have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ____

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services I receive at this office.

Cancellation Policy – 24 hour notice for all scheduled appointments - $65 fee

___________________________________ **Patient or Authorized Person's Signature**

_____ - _____ - _____ **Date Completed**

Nicholl Chiropractic Inc. NOTICE OF PRIVACY PRACTICE

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost @ $25.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the office at (916) 594-7630. If she/he is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Nicholl Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

______________________________ ____________ ____________

Patient's Name DOB HR#

______________________________ ____________

Patient signature Date

______________________________ ____________

Witness Date

Office Fee Schedule

Service	***Fees***
Consultation	Free
Initial Exam	$50.00 - 137.00
X-rays	$87.00 - 200.00
Adjustments	$55.00 – 75.00
Ancillary Procedures	$30.00 – 60.00

Financial Policy

You will be expected to pay for your chiropractic care at the time service is rendered unless discussed with the office prior.

Cash- Charges for care in this office are due at the time of your service. Cash patients are able to obtain upwards of a **60% discount** under representation from Compliant Coupons. Every patient will be automatically enrolled with Compliant Coupons.

Health Insurance- Every patient is asked to place a $130 deposit for services rendered on the 1st appointment. Once a diagnosis code is established by the doctor, office staff will obtain detailed information on coverage opportunities in the office. If insurance covers care, the deposit will be returned to patient or applied towards co-pays and deductibles. If no coverage is present, no additional charges will be placed for the 1st visit. We will accept your assignment of benefits; however you must remember you are directly responsible for your bill.

"If my health insurance company denies payment, I agree to be personally and fully responsible for payment."

Medicare- Medicare will not pay for x-rays or an exam; however they require them before they will pay for your treatments'. You will be responsible for the cost of your x-rays' and exam. If you have not met your deductible, this must also be satisfied. Medicare will cover 80% of the adjustment; no additional services are covered. A yearly deductible of $147 must be met for Medicare to pay for their portion. If you have not met your deductible you will be responsible for this.

Personal Injury- (Auto Accident) If you have medical coverage (Med-Pay) on your auto insurance policy, we will bill them for prompt and direct payment for your care. (Med-Pay will cover your doctor's bill regardless of who was at fault). If you do not have Med-Pay we will defer to a third party lien however we do require that you obtain an attorney. If you do not have one, we can recommend several attorney's for you.

Cancellation Policy

24 hour cancellation for scheduled appointments must be respected or appointment will be charged $65.

____ _________________________

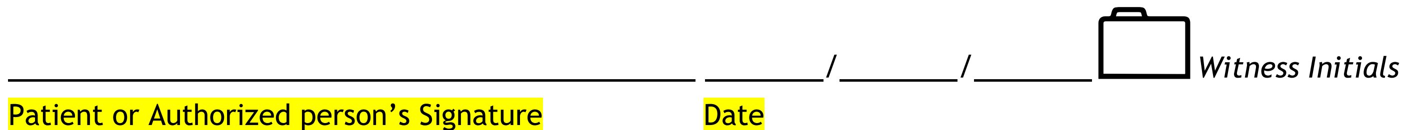
Patient's Signature Date

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Nicholl Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.



____ ________/________/________ *Witness Initials*

Patient or Authorized person's Signature Date

Informed Consent

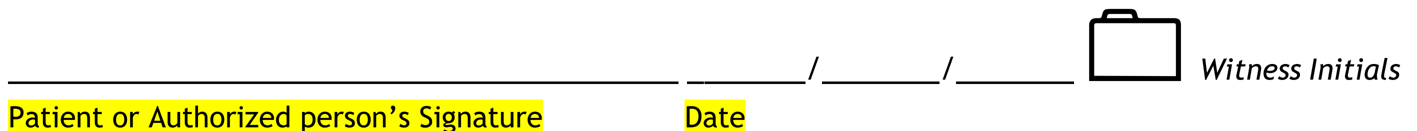
REGARDING: X-rays/Imaging Studies:

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.



____ ________/________/________ *Witness Initials*

Patient or Authorized person's Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: ____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information to:

[ ] Spouse____

[ ] Child(ren)_______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages: Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: ____ Date: ____/____/_____

Consent to Treat a Minor

The undersigned hereby requests and authorizes Dr. Tim Nicholl to perform diagnostic testing and render chiropractic adjustments to ____, who is a minor.

This authorization extends to radiographic examination.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse or former spouse or another parent is not required.

Patient Name: ____

Parent/Guardian signature_________________________________ Date: ____/____/_____