

GATEWAY CHIROPRACTIC, P.C.
14930 LaPlaisance Rd #116 Monroe, MI 48161
(734) 242-4422

Date: _____

Name(last) _____ (first) _____ (MI) _____

Address _____
(Street) (City) (State) (Zip)

Home Phone # _____ Cell # _____

Birth Date _____ Email _____

Marital Status: S M OTHER SS# _____

Occupation: _____ Employer: _____

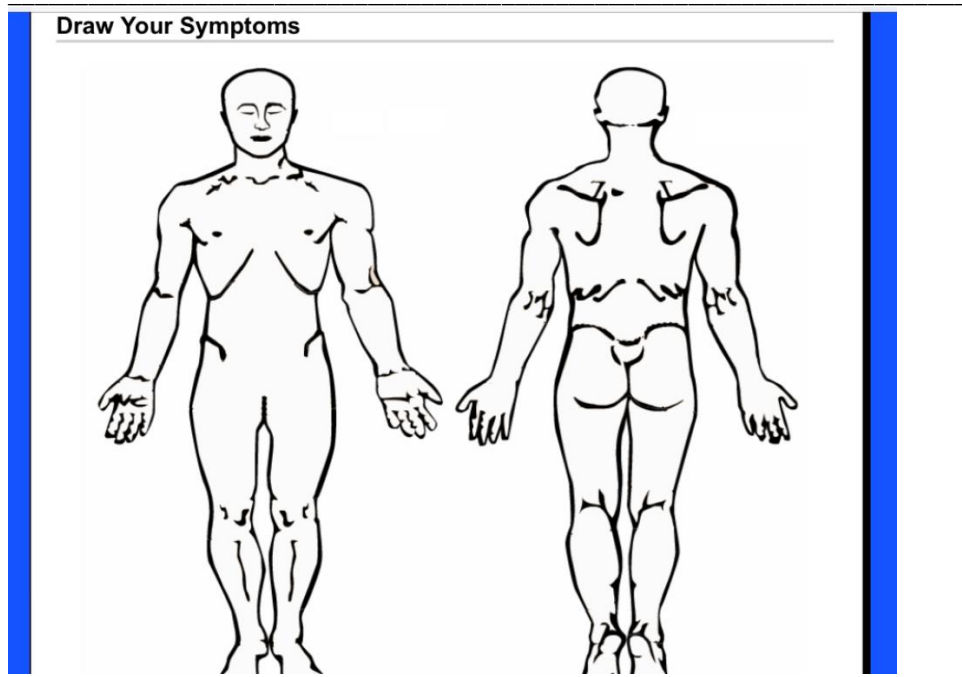
Emergency Contact: _____ Phone: _____

Health INS: BCBS PPOM AETNA PARAMOUNT NONE OTHER _____

Policy Holder: _____ Policy Holders DOB: _____

Enrollee ID# _____ Group # _____

What is your chief complaint for your visit today?



What symptoms are you having? Check all that apply.

- | | | | | | |
|------------------|--------------|--------------|--------------|---------------|---------------|
| Aching ___ | Numbness ___ | Stabbing ___ | Diffuse ___ | Radiating ___ | Tightness ___ |
| Dull ___ | Sharp ___ | Tingling ___ | Cramping ___ | Pulsating ___ | Throbbing ___ |
| Excruciating ___ | Shooting ___ | Weakness ___ | Burning ___ | Pounding ___ | Stabbing ___ |

Rate the severity of your pain at its least and greatest times by checking two boxes on scale.

0 1 2 3 4 5 6 7 8 9 10

When did this happen? _____

How did this happen? _____

How often do you feel the symptoms?

Less than 10% 25% 50% 75% 100%

What makes symptoms better? _____

What makes symptoms worse? _____

Have you had previous Chiropractic care? YES or NO If YES, when was last adjustment ? _____

What other treatments have you done for this symptom?

Chiropractic _____ Pain Medication _____ Exercise _____

Ice _____ Heat _____ Rest _____

How is this affecting your daily life? What activities are you unable to do?

Height _____ Weight _____ Do you use: **Alcohol** **Tobacco** **Caffeine**

Any previous illnesses/injuries? Please List

List all Surgeries:

Type _____ When _____

Type _____ When _____

Type _____ When _____

Current medications?

Name _____ For what _____ How Long _____

Name _____ For what _____ How Long _____

Name _____ For what _____ How Long _____

Name _____ For what _____ How Long _____

Please list any allergies : _____

Any family history of back/neck problems? _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ If yes, please explain to doctor upon examination

Past and Present Conditions

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Headaches _____

Neck Pain _____

Low Back Pain _____

Diabetic problems _____

Breathing problems _____

Sinus problems _____

Eye problems _____

Indigestion _____

Skin problems _____

Constipation _____

Liver problems _____

Weight problems _____

Dizziness _____

Pins/Needles in arms/hands _____

Pain in legs and feet _____

Heart Problems _____

Asthma _____

Allergies _____

Ear problems _____

Stomach problems _____

Gall Bladder problems _____

Bladder problems _____

Kidney problems _____

Fatigue _____

Weak Immune system _____

TMJ _____

Pain in joints _____

High Blood Pressure _____

Thyroid problems _____

Bowel problems _____

Menstrual problems _____

Sleeping problems _____

Whom can we thank for referring you to our office? _____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at Gateway Chiropractic, P.C. and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

* _____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original

* _____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

* _____ INITIALS

MISSED APPOINTMENT POLICY

Gateway Chiropractic, P.C. reserves the right to bill any patient \$38 for a missed appointment with no advance notice of cancellation or reschedule.

* _____ INITIALS

Patient Financial Responsibility

Payment is Expected at Time of Service

For all patients, payment of insurance co-pays and services not covered by insurance are to be paid for at the time the service is rendered. We will try to get insurance benefits as a courtesy for you. What we receive from the insurance company is a quote of benefits, not a guarantee. You are responsible for any balances not covered by your insurance, including rejected claims. While every effort will be made to submit claims in accordance with insurance requirements for payment, in the event of a dispute or rejection, you as the insured or guarantor are responsible for payment. The insurance contract is between you and your insurance provider, not between the insurance company and Gateway Chiropractic.

Insurance claims not paid within 90 days after the original date of service will become the responsibility of the patient/insured.

Signature

Date

PAYMENT RESPONSIBILITY FOR DIVORCED/SEPARATED PARENTS

The person who brought the child in for services is responsible for payment. This office cannot be responsible for collecting from any other individual.

I acknowledge that I have read and understood this payment policy.

Signature

Date

Consent for Purposes of Treatment and Healthcare Operations

I acknowledge that Gateway Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review Gateway Family Chiropractic's Notice of Privacy prior to signing this document. Gateway Family Chiropractic's Notice of Privacy Practices has been provided to me. 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 my bills or in the performance of health care operations of Gateway Family Chiropractic. The Notice of Privacy Practices for Gateway Family Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and Gateway Family Chiropractic's duties with respect to my protected health information.

Gateway Family Chiropractic 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 offices 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

Print Name of Patient or Personal Representative