Applied Modern Health Chiropractic

GENERAL INFORMATION

Name:_____

Date of Birth:_____/_____/_____ **Social Security Number:**_____

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

Street Address:_____

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

Email Address:_____

Ethnicity (optional):_____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other

Have you ever seen a chiropractor before? ☐ Yes ☐ No

Is this injury auto or work related? ☐ Yes ☐ No

How did you hear about us? ☐ Referral ☐ Friend ☐Instagram ☐Google ☐Facebook

☐ Other (please specify): _____

Insurance:_____ Telephone Number:_____

Claims Mailing Address:_____

Subscriber ID#:_____ Group #:_____

Sponsor Name:_____ Date of Birth:_____

Emergency Contact:_____

Phone:_____ **Relationship to Patient:**_____

Health Check

Past	Present		Past	Present	
☐	☐	Headache	☐	☐	High Blood Pressure
☐	☐	Neck Pain	☐	☐	Heart Attack
☐	☐	Upper Back Pain	☐	☐	Chest Pains
☐	☐	Mid Back Pain	☐	☐	Stroke
☐	☐	Low Back Pain	☐	☐	Angina
☐	☐	Hip Pain	☐	☐	Kidney Stones
☐	☐	Shoulder Pain	☐	☐	Kidney Disorders
☐	☐	Elbow/Upper Arm Pain	☐	☐	Bladder Infection
☐	☐	Wrist Pain	☐	☐	Painful Urination
☐	☐	Hand Pain	☐	☐	Incontinence
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite
☐	☐	Jaw Pain	☐	☐	Abdominal Pain
☐	☐	Joint Pain Stiffness	☐	☐	Ulcer
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder
☐	☐	Rheumatoid Arthritis	☐	☐	General Fatigue
☐	☐	Cancer	☐	☐	Muscular incoordination
☐	☐	Tumor	☐	☐	Visual Disturbances
☐	☐	Asthma	☐	☐	Dizziness
☐	☐	Chronic Sinusitis	☐	☐	Diabetes
☐	☐	Other:_____	☐	☐	Excessive Thirst
			☐	☐	Frequent Urination
			☐	☐	Smoking/Tobacco Use
			☐	☐	Drug/ Alcohol Dependence
			☐	☐	Allergies
Past	**Present**	**Females Only**	☐	☐	Depression
☐	☐	Birth Control Pills	☐	☐	Systemic Lupus
☐	☐	Hormonal Replacements	☐	☐	Epilepsy
☐	☐	Pregnancy	☐	☐	Dermatitis/ Eczema/ Rash
			☐	☐	HIV/AIDS

Please list prescription medications you are currently taking:_____

_____

Please list all over-the -counter medications you are currently taking:_____

_____

Please list all surgical procedures you have had:_____

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Self-Assessment Survey

Please briefly answer the following questions:

What brings you in today?

_____

_____

_____

_____

When did the problem start?

_____

_____

_____

_____

What have you done for this problem?

_____

_____

_____

_____

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Acknowledgement of Notice of Privacy Practices

I acknowledge that:

- I have received a copy of the Medical Practice's Notice of Privacy Practices.
- The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice.
- I was able to view the Notice of Privacy Practices on the first day I received health care service after April 14, 2003.
- If I came in for health services in an emergency treatment situation, I would be able to view the Notice as soon as reasonably practical after the emergency situation ended.
- I was able to review the Medical Practice's Notice of Privacy Practices at the place where I went for health care services.
- I know that I can ask for a copy of the Notice of Privacy Practices to take with me.

_____ _____

Patient Signature, or Patient's Legal Representative Date

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Informed Consent

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below 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 backup for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. 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 possible 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 on 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 the 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.

Dr. Moe Hazimi D.C.

Signature of Patient:_____ Date:_____

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative_____Date:_____

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Office Policy

Protected Health Information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are **required** to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Applied Modern Health Chiropractic will only disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

PATIENT RESPONSIBILITY FOR PAYMENT

I understand that I am responsible for any and all balances not covered by my insurance company. I acknowledge that my insurance company, including Medicare, (where applicable) may limit the number of visits per year and that I am financially responsible for additional visits rejected by the insurance company. **In addition, I understand that I am not to allow my balance exceed $130.00. I understand that if I would like a copy of medical records there will be an additional charge.** In the event that I terminate my care, any balance will be immediately due and payable. If it becomes necessary to assign my account for collection, I will be responsible for any and all charges incurred for collection.

_____ _____

Patient Signature, or Patient's Legal Representative Date

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Cancellation/No Show Policy

AMH Chiropractic requires a 24 hour notice of cancellation for any scheduled appointment. Failure to provide a notice of 24 hours will result in a cancellation fee. The missed (and/or rescheduled) visit will be subject to a fee of $25.00 for a standard adjustment appointment or $50.00 for a massage/adjustment appointment. This fee will be applied immediately and payment due at the next scheduled visit. We understand your time is valuable and your continued care is important us. Please let us know in advance if you will be unable to make your appointment.

If you need to cancel or reschedule an appointment please call the office at 734-525-0200.

I understand it is my responsibility to provide AMH Chiropractic with 24 hours notice if I am unable to make my scheduled appointment time. I understand any fee incurred by my failure to provide adequate notice will be applied to my account and due at the time of my next visit.

_____ _____

Patient Signature, or Patient's Legal Representative Date