Preferred Chiropractic

3985 N. Michigan Ave. Saginaw, MI 48604

Please complete this form. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. Thank You.

General Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext. _____

Cell Phone ( ) _____ E-mail Address _____

What do you prefer to be called? _____ **How were you referred to us?** _____

Employer/Occupation _____ Hours you usually work: _____ to _____ Okay to call work? **Y N**

Sex: M ____ F ____ Birth date: ____ / ____ / _____ Age: ____ Social Security Number: _____ - _____ - _____

Marital Status: M S W D Spouse's Name _____ Number of Children ____

Have you ever seen a Chiropractor before? **Y N** If Yes, Who and When? _____

Health Information

Is your condition the result of an Auto Accident? **Y N** Is your condition the result of a Work related injury? **Y N**

Have you EVER been in ANY KIND of Auto Accident? Y N If Yes, When? Past Year ___ Past 5 yrs ___ Over 5 yrs ___

Describe: _____

What is your major complaint? _____ Other complaints? _____

How long have you had this condition? _____ Have you had similar conditions in the past? **Y N**

What areas of your life have been affected by your pain and symptoms? _____

_____

What activities aggravate your condition? _____

Is your condition: Getting progressively worse? **Y N** Constant? **Y N** Does it Come and Go? **Y N**

Is your condition interfering with: Work? **Y N** Sleep? **Y N** Daily routine? **Y N** Other _____

How long has it been since you felt good? _____ Have any other Doctors treated you for this condition? **Y N**

If Yes, Who and When? _____

List all surgical operations and years _____

How old is your Mattress? _____ Is it Comfortable? **Y N**

Do you wear: Heel lifts? **Y N** Sole lifts? **Y N** Arch supports? **Y N** Other _____

For Women: Are you pregnant? **Y N** If Yes, how far along? _____ Are you Nursing? **Y N**

Patient's Primary Care Physician: _____

Address: _____ Phone Number: _____

Fax Number: _____

I guarantee that this form was completed correctly to the best of my knowledge. I authorize the Doctors and/or staff at Preferred Chiropractic to perform any services necessary during my diagnosis and treatment. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____

□ Adult Patient □ Parent or Legal Guardian □ Spouse

Patient Information Form

I, _____, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I fully understand that I am solely responsible for any balance not paid for by my insurance company, and that if my insurance carrier does not cover the charge for any treatment, claiming that the treatment was not "medically necessary", then I understand and agree that I will be responsible for the cost of the treatment provided. I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I understand that I am responsible for any and all additional fees that are incurred in an effort to collect on my past due account (including legal fees, collection agency fees, interest, etc). I also understand that if I suspend or terminate my care and treatment, any unpaid fees for professional services rendered to me will be immediately due and payable.

Signature _____ **Date** _____

□ Adult Patient □ Parent or Legal Guardian □ Spouse

IF YOUR CONDITION IS NOT related to an Auto Accident/Work related/Personal injury, please sign and date below.

Auto Accident/Work Related/Personal Injury Waiver

I, _____, guarantee that the treatment that I am about to receive at Preferred Chiropractic is not in any way the result of an Auto Accident, Work related injury, or Personal injury.

Signature _____ **Date** _____

□ Adult Patient □ Parent or Legal Guardian □ Spouse

Date: ____/____/_____

Authorization for release of Medical Information

I, the undersigned patient, authorize the release of my x-rays and other related health information to:

Primary Care Physician:

_____

_____

_____

This Authorization or a photocopy thereof, authorizes Shields Chiropractic to furnish all information regarding my condition to the above-named Doctor, Hospital or Facility. This includes the history obtained, x-rays and any physical findings, diagnosis and prognosis.

Patient Name _____ Patient Signature _____

Preferred Chiropractic

3985 N. Michigan Ave. Saginaw, MI 48604

Notice of Privacy Practices for Protected Health Information

This Notice describes how Medical Information about you may be used and disclosed, as well as how you can get access to this information. Please review it carefully.

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information at any time. We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notice If we make a change, it will apply to all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

Uses and Disclosures

Here are some examples of how we might use or disclose your health care information:

1. We may have to disclose your health information to another health care provider, hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination, treatment and billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use information in your file for quality control or administrative purposes to run our practices.
4. We may use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results, special promotions, referral information, etc.). 164.520(b)(1)(iii)(A). If you are not at home a message will either be left on your answering machine, left with a family member and/or mailed to your home.

You have the right to refuse to give us an authorization to contact you regarding your care at this office, or to limit use and disclosure of your health information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care (including billing you by mail or collection proceedings). You cannot refuse to receive monthly statements or billings, nor can you limit the access to your insurance company if they are responsible for payment. You may inspect or copy the information that we use to contact you regarding your care at any time.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Your Right to Limit Uses and/or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

Revoking Your Authorization

You may revoke your authorization to us at any time in writing. There are two (2) circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Confidential Communication

We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

Amending Your Health Information

You have the right to request that we amend your health information for seven (7) years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

Inspecting/Copying Your Health Information

You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. The health information is available up to seven (7) years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. An appointment will be set up within thirty (30) days of your written request for you to inspect your records in our office. Requested copies of your records will be available within two (2) business days of the written request and **there will be a charge of $.50 per page copied. Copies can be made of your x-rays for a charge of $10.00 for each film.** The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

Re-Disclosure

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

Accounting of Disclosures of Your Records

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six (6) years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- Those required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- Those necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- Those requested for national security, intelligence purposes, or law enforcement officers.
- Those that were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a twelve (12) month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Complaints

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written correspondence should be addressed to:

Preferred Chiropractic
Attn: HIPAA Compliance Officer
3985 N. Michigan Ave.
Saginaw, MI 48604

Secretary for Health & Human Services
200 Independence Ave. S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This notice is effective as of _____. This notice will expire six (6) years after the date upon which the record was created. By signing below, I acknowledge that I understand and agree to the information stated above. I also acknowledge that I was given the opportunity to read all the information and ask questions.

Signature _____ **Date** _____

□ Adult Patient □ Parent or Legal Guardian □ Spouse

Printed Name _____ **Relationship to Patient** _____
(If not Patient)

Preferred Chiropractic

If you or any member of your family have experienced any of the following, please mark the appropriate box.

Condition	Self	Spouse	Mother	Father	Sibling	Child	Child	Child
Allergies								
Anemia								
Appendicitis								
Arthritis								
Asthma								
Breathing Problems								
Bursitis								
Cancer								
Chest Pain								
Colitis								
Diabetes								
Digestive Problems								
Dizziness								
Earaches								
Eye Problems								
Frequent Colds								
Headaches								
Hearing Problems								
Heart Problems								
Hemorrhoids								
Hernia								
Impotency								
Liver Problems								
Low Back Pain								
Menstrual Problems								
Mid Back Pain								
Neck Pain								
Nervousness								
Neuritis								
Pain in Arms or Hands								
Pain in Legs or Feet								
Shingles								
Shoulder Pain								
Sinus Problems								
Skin Disorders								
Throat Problems								
Thyroid Disorders								
Tonsillitis								
Urination Problems								

Signature Date

Family Health History

Neck Pain and Disability Index

Name: _____ Chart #: _____ Date: _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section, please fill in only ONE box, which most closely describes your problem.

Section 1 – Pain Intensity

- ☐ A. I have no pain at the moment.
- ☐ B. The pain is very mild at the moment.
- ☐ C. The pain is moderate at the moment.
- ☐ D. The pain is fairly severe at the moment.
- ☐ E. The pain is very severe at the moment.
- ☐ F. The pain is the worst imaginable at the moment.

Section 2 – Personal Care

- ☐ A. I can look after myself normally without causing extra pain.
- ☐ B. I can look after myself normally but it causes extra pain.
- ☐ C. It is painful to look after myself and I am slow and careful.
- ☐ D. I need some help but manage most of my personal care.
- ☐ E. I need help every day in most aspects of self-care.
- ☐ F. I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ A. I can lift heavy weight without extra pain.
- ☐ B. I can lift heavy weight but it gives extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ☐ E. I can lift very light weights.
- ☐ F. I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ A. I can read as much as I want with no pain in my neck.
- ☐ B. I can read as much as I want with slight pain in my neck.
- ☐ C. I can read as much as I want with moderate pain in my neck.
- ☐ D. I can't read as much as I want because of moderate pain in my neck.
- ☐ E. I can hardly read at all because of severe pain in my neck.
- ☐ F. I cannot read at all.

Section 5 – Headaches

- ☐ A. I have no headaches at all.
- ☐ B. I have slight headaches which come infrequently.
- ☐ C. I have moderate headaches which come infrequently.
- ☐ D. I have moderate headaches which come frequently.
- ☐ E. I have severe headaches which come frequently.
- ☐ F. I have headaches almost all the time.

Section 6 – Concentration

- ☐ A. I can concentrate fully when I want with no difficulty.
- ☐ B. I can concentrate fully when I want with slight difficulty.
- ☐ C. I have a fair degree of difficulty in concentrating when I want.
- ☐ D. I have a lot of difficulty in concentrating when I want.
- ☐ E. I have a great degree of difficulty in concentrating when I want.
- ☐ F. I cannot concentrate at all.

Section 7 – Work

- ☐ A. I can do as much work as I want.
- ☐ B. I can only do my usual work, but no more.
- ☐ C. I can do most of my usual work, but no more.
- ☐ D. I can hardly do any work at all.
- ☐ E. I cannot do my usual work.
- ☐ F. I can't do any work at all.

Section 8 – Driving

- ☐ A. I can drive my car without any neck pain.
- ☐ B. I can drive my car as long as I want with slight pain in my neck.
- ☐ C. I can drive my car as long as I want with moderate pain.
- ☐ D. I can't drive my car as long as I want because of moderate pain.
- ☐ E. I can hardly drive at all because of severe pain in my neck.
- ☐ F. I can't drive my car at all.

Section 9 – Sleeping

- ☐ A. I have no trouble sleeping.
- ☐ B. My sleep is slightly disturbed (less that 1 hr. sleepless)
- ☐ C. My sleep is mildly disturbed (1-2 hrs. sleepless)
- ☐ D. My sleep is moderately disturbed (2-3 hrs. sleepless)
- ☐ E. My sleep is greatly disturbed (3-5 hrs. sleepless)
- ☐ F. My sleep is completely disturbed (5-7 hrs. sleepless)

Section 10 – Recreation

- ☐ A. I am able to engage in all recreational activities with no neck pain.
- ☐ B. I am able to engage in all my recreational activities, with some pain in my neck.
- ☐ C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ E. I can hardly do any recreational activities because of pain.
- ☐ F. I can't do any recreational activities at all.

Office Use Only Date: Score:

Preferred Chiropractic
3985 N. Michigan Avenue
Saginaw, Michigan 48604
989-771-2225(BACK)

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Revised Oswestry Low Back Pain and Disability

Name: _____ Chart #:_____ Date: _____

Please Read Instructions:
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in only ONE box, which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ A. The pain comes and goes and is very mild.
- ☐ B. The pain is mild and does not vary much.
- ☐ C. The pain comes and goes and is moderate.
- ☐ D. The pain is moderate and does not vary much.
- ☐ E. The pain comes and goes and is very severe.
- ☐ F. The pain is severe and doesn't vary much.

Section 2 – Personal Care
- ☐ A. I can look after myself normally without causing extra pain.
- ☐ B. I can look after myself normally but it causes extra pain.
- ☐ C. It is painful to look after myself and I am slow and careful.
- ☐ D. I need some help but can manage most of my personal care.
- ☐ E. I need help every day in most aspects of self-care.
- ☐ F. I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ A. I can lift heavy weight without extra pain.
- ☐ B. I can lift heavy weight but it gives extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor.
- ☐ D. Pain prevents me from lifting heavy weights, but I can mange if they are conveniently positioned.
- ☐ E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ☐ F. I can only lift very light weights at the most.

Section 4 – Walking
- ☐ A. I have no pain walking.
- ☐ B. I cannot walk more than one mile without increasing pain.
- ☐ C. I cannot walk more than ½ mile without increasing pain.
- ☐ D. I cannot walk more than ¼ mile without increasing pain.
- ☐ E. I can walk with crutches.
- ☐ F. I cannot walk at all without increasing pain.

Section 5 – Sitting
- ☐ A. I can sit in any chair as long as I like.
- ☐ B. I can only sit in my favorite chair as long as I like.
- ☐ C. Pain prevents me from sitting more than one hour.
- ☐ D. Pain prevents me from sitting more than a half hour.
- ☐ E. Pain prevents me from sitting more than 10 minutes.
- ☐ F. I avoid sitting because it increases pain straight away.

Section 6 – Standing
- ☐ A. I can stand as long as I want without pain.
- ☐ B. I have some pain on standing but it does not increase with time.
- ☐ C. I cannot stand for longer than one hour without increasing pain.
- ☐ D. I cannot stand for longer than ½ hour without increasing pain.
- ☐ E. I can't stand for longer than 10 minutes without increasing pain.
- ☐ F. I avoid standing because it increases the pain straight away.

Section 7 – Sleeping
- ☐ A. I get no pain in bed.
- ☐ B. I get pain in bed but it doesn't prevent me from sleeping well.
- ☐ C. Because of pain my normal nights sleep is reduced by < ¼.
- ☐ D. Because of pain my normal nights sleep is reduced by < ½.
- ☐ E. Because of pain my normal nights sleep is reduced by < ¾.
- ☐ F. Pain prevents me from sleeping at all.

Section 8 – Traveling
- ☐ A. I get no pain while traveling.
- ☐ B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ E. Pain restricts all forms of travel.
- ☐ F. Pain prevents all forms of travel except that done lying down.

Section 9 – Social Life
- ☐ A. My social life is normal and gives me no pain.
- ☐ B. My social life is normal but increases the degree of pain.
- ☐ C. Pain limits my more energetic interests, e.g. dancing, etc.
- ☐ D. Pain has restricted my social life and I do not go out very often.
- ☐ E. Pain has restricted my social life to my home.
- ☐ F. I have hardly any social life because of the pain.

Section 10 – Changing Degree of Pain
- ☐ A. My pain is rapidly getting better.
- ☐ B. My pain fluctuates but overall is definitely getting better.
- ☐ C. My pain seems to be getting better but improvement is slow.
- ☐ D. My pain is neither getting better nor worse.
- ☐ E. My pain is gradually worsening.
- ☐ F. My pain is rapidly worsening.

Office Use Only Date: Score:

Preferred Chiropractic
3985 N. Michigan Avenue
Saginaw, Michigan 48604
989-771-2225(BACK)

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature:_____

ASSIGNMENT OF RIGHTS, BENEFITS AND CAUSES OF ACTION

In consideration of PREFERRED CHIROPRACTIC, LLC agreeing to pursue payment of my medical bills with any payer responsible for paying the charges I incurred for my medical care and treatment with Medical provider (Medical provider bills), I assign, transfer and convey to Medical provider:

- All present, past due or owing benefits payable to me by any payer for my Medical provider bills.
- The right to claim benefits with and/or to bring a lawsuit against any payer to recover payment of my Medical provider bills.
- The right to intervene in any lawsuit or proceeding that involves the payment of my Medical provider bills.
- The right to recover interest or attorney's fees or other penalties to which I am entitled from any payer in connection with seeking payment of my Medical provider Bills.
- The right to appeal the denial of payment of my Medical provider bills.
- The right to receive payment of my Medical provider bills directly from any payer.
- The right to receive all documents to which I am entitled from any payer.

Payer is any entity providing insurance coverage or benefits for my medical care by law or contract including, but not limited to, any employer-sponsored benefit plan, liability or health insurance carrier, worker's disability compensation insurance carrier, no-fault automobile insurance carrier, and the Michigan Automobile Insurance Placement Facility (MAIPF) or Michigan Assigned Claims Plan (MACP). I designate Medical provider and its attorneys as my authorized representatives under ERISA and its claims regulations, or any other law, for the purpose of pursuing payment of my Medical provider bills. I agree to fully cooperate with Medical provider in pursuing payment of my Medical provider bills. I will not interfere with or compromise Medical provider's ability to recover my Medical provider bills. I waive any and all rights to settle, release or retain payment of my Medical provider bills. I understand that the right to payment of my Medical provider bills belongs only to Medical provider. I consent to the imposition of constructive trust over my insurance benefits in favor of the Medical provider. If the Medical provider has made a claim for my benefits or filed a lawsuit to recover payment of my Medical provider bills, this Assignment Of Rights, Benefits And Causes Of Action is retroactive to the date Medical provider filed the litigation or made the claim. This Assignment Of Rights, Benefits And Causes Of Action cannot be revoked without Medical provider's written consent. I understand that Medical provider will only be attempting to recover my Medical provider bills and not any other benefits to which I may be entitled.

If one or more provisions of this Assignment Of Rights, Benefits And Causes Of Action shall be invalid, illegal or unenforceable in any respect under any applicable law or decision, the validity, legality, and enforceability of the remaining provisions shall not be affected or impaired in any way.

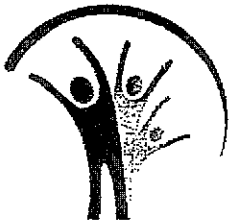
Dated: _____ By: _____

Address: _____

_____

Telephone: _____

E-mail: _____



Preferred Chiropractic

Name:_____
Date:_____

Cell Phone:_____
Other Phone:_____
Preferred Method of Contact:_____
Fax Number(if available)_____
Email Address_____
Race: (Circle One) African American American Indian Asian Native Hawaiian Pacific Islander White

Please list all medications you are taking at this time and precise dosage per day in mg.
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Do you have any allergies to any medications ? Yes___ No___
Circle any that apply: nausea vomiting hives headaches fever
_____
_____
_____

Do you use tobacco: yes__ no __
What type?_____
If cigarettes, how many packs per day? _____
If cigars, how many per day? _____
If any other, how much? _____