RECOVERED
CHIROPRACTIC

Welcome to Our Office

Thank you for choosing our practice for your chiropractic and massage needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: _____ Number of Children : _____

Email Address: _____ Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

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

PHONE NUMBERS

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Best Time And Place To Reach You Is:

_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

INSURANCE INFO

Do you have health care insurance? ☐ Yes ☐ No Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Is patient covered by additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Insurance Company: _____ Subscriber's Name : _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

Are you here due to an: ☐ Auto Accident ☐ On the Job Injury ☐ Other Accident: _____

If yes, please complete the following: Date of Accident: _____

To whom have you reported the accident: ☐ Auto Ins. ☐ Workers Comp ☐ Other: _____

Insurance Company: _____ Claim Number: _____

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HEALTH HISTORY

Have you had previous chiropractic care? □ Yes □ No If yes, Where? _____
When was your last adjustment? _____ Could you be pregnant? □ Yes □ No
What are your Major/Primary complaints? How long have they been bothering you?
1) _____ 1) _____
2) _____ 2) _____
Have you had any falls, auto accidents or injuries? □ Yes □ No If yes, please describe below:
Month/Year: _____ Type of Accident: _____ Comments _____
Month/Year: _____ Type of Accident: _____ Comments _____
Have you ever had surgery? □ Yes □ No If yes, please describe below:
Month/Year: _____ Type of Surgery: _____ Comments _____
Month/Year: _____ Type of Surgery: _____ Comments _____
Are you currently taking any medications or vitamins? □ Yes □ No If yes, please describe below:
Medication Name _____ Dose per Day _____ For how long _____
Medication Name _____ Dose per Day _____ For how long _____
Medication Name _____ Dose per Day _____ For how long _____

Please check any of the following that you have ever experienced:

- □ Headache
- □ Shooting Head Pains
- □ Sinus Trouble
- □ Loss Of Smell
- □ Allergies
- □ Asthma
- □ Loss Of Taste
- □ Thyroid Trouble
- □ Twitching Of Face
- □ Loss Of Memory
- □ Fatigue
- □ Depression
- □ Dizziness
- □ Scoliosis
- □ Chest Pain
- □ Fainting
- □ Loss Of Balance
- □ Ringing In Ears
- □ Blurred Vision
- □ Lights Bother Eyes
- □ Neck Pain
- □ Muscle Spasms In Neck
- □ Grinding In Neck
- □ Tightness In Shoulders & Arms
- □ Pain In Shoulders & Arms
- □ Pins Needles In Arms & Hands
- □ Numbness In Arms or Hands
- □ Cold Hands Or Fingers
- □ Tonsillitis
- □ Mid Back Pain
- □ Low Back Pain
- □ Numbness In Legs Or Feet
- □ Pins & Needles In Legs
- □ Pain In Legs And Feet
- □ Swollen Joints
- □ Swollen Ankles
- □ Cold Feet & Toes
- □ Hip Pain
- □ Painful Joints
- □ Ulcers
- □ Constipation
- □ Kidney Trouble
- □ Menstrual Pain
- □ Menstrual Irregularity
- □ Prostate Trouble
- □ Diabetes
- □ Hiv +
- □ Aids
- □ Stroke
- □ Heart Attack
- □ Hernia
- □ Sleeping Problems
- □ Shortness Of Breath
- □ Nervousness/ Anxiety
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Anemia
- □ Stomach Trouble
- □ Irritability
- □ Gall Bladder Trouble
- □ Indigestion
- □ Intestinal Gas
- □ Bed Wetting

Do you smoke? Circle: Yes or No

AUTHORIZATION

Assignment/Release of Information: I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office or professional, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office. I authorize this office to release any information pertinent to my case to any insurance company, adjustor, and/or attorney involved in this case.

Signature: _____ Date: _____

Financial Responsibility: I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment and any services rejected by my insurance company.

Signature: _____ Date: _____

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Informed Consent For Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic examinations, diagnosis and analysis.

Like all forms of health care, chiropractic care offers considerable benefits. However, as with all forms of health care, the practice of chiropractic involves some risks to treatment including, but not limited to; fractures, disc injuries, strokes, dislocations and sprains. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury.

I understand that the doctor will use his hands and/or a mechanical device upon my body during treatment. The doctor will not give any treatment or health care if he is aware that such care may be contraindicated (a condition which makes a particular treatment or procedure inadvisable). Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician.

The chiropractic physician provides a specialized, non-duplicating health care service. Our Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a chiropractic physician at Recovered Chiropractic, I am authorizing them to proceed with any treatment and/or adjunct therapies that may be necessary. There has been no promise, implied or otherwise, of a cure for any symptom, disease or conditions as a result of treatment at Recovered Chiropractic. All my questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction and the benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care of this basis.

_____ _____

Patient Signature or Legal Guardian | Today's Date

_____ _____

Print Patient Name | Relationship to Patient

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Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, _____, hereby authorize **Recovered Chiropractic** to use the following protected health information (PHI):

- Your name in a testimonial, only if you wish to write one for us
- Your name and address, should we send you a newsletter, coupons, birthday/holiday cards or marketing materials about chiropractic
- Your name on our New Patient Welcome Board for a month following your first visit

I wish for you to disclose my PHI information to _____

[Specifically name the entity receiving the requested PHI]

This protected health information is being used or disclosed for the following purposes:

_____

[List specific purposes here.]

This authorization shall be in force and effect until YOIJ NOTIFY US IN WRITING at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **DR. MARC GUSSE** at **5140 HIGHLAND ROAD WATERFORD, MI 48327**. understand that a revocation is not effective to the extent that **RECOVERED CHIROPRACTIC** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

RECOVERED CHIROPRACTIC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

The use or disclosure requested under this authorization will not result in direct or indirect remuneration to RECOVERED CHIROPRACTIC from a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Relationship to Patient

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Financial Policy

Welcome to our office. Thank you very much for choosing us to care for you. It is part of our "Extra Caring" approach to healthcare to openly discuss our financial policy with you. Experience has shown us that mutual understanding of money matters makes for a better relationship. The following is a statement of our financial policy. We require that you read, agree to and sign it prior to any treatment. All patients must complete our entry forms.

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
  - Except for the portion that your insurance company has approved.
  - We accept Cash, Check, Visa, MasterCard, Discover and American Express.
  - $5.00 service fee will be added monthly to any account balance carried over 30 days.
  - In the case that your account needs to be referred to a collection agency, there will be a $25.00 processing fee added to your balance along with any agency/court fees.
- **REGARDING INSURANCE**
  - We do accept assignment of insurance benefits. We do require that you pay your deductible (if not already met), and your co-payment at the time of service. The balance of your full bill is your responsibility whether your insurance carrier pays or not. **Please remember that your insurance policy is a contract between you and your insurance company.** The portion of your claims that your insurance company charges you will be reflected on your account balance. In order to continue active care your account balance cannot exceed $100.00.
- **MEDICARE**
  - We do accept assignment of benefits from Medicare and we do participate. There is a co-pay for each visit after the annual Medicare deductible is met. **There is no guarantee of how many visits Medicare will pay for. Medicare will not pay for maintenance care.**
- **SUPPLIES**
  - Not all insurance companies pay for supplies. You will be responsible for all supplies given to you on the date they are prescribed. If your insurance company reimburses the charge, we will refund or credit the amount charged to you.

Thank you for understanding our financial policy. Please let us know if there are any questions or concerns.

I have read, understand, and agree to the above policies.

_____
Patient Signature or Legal Guardian

_____
Date

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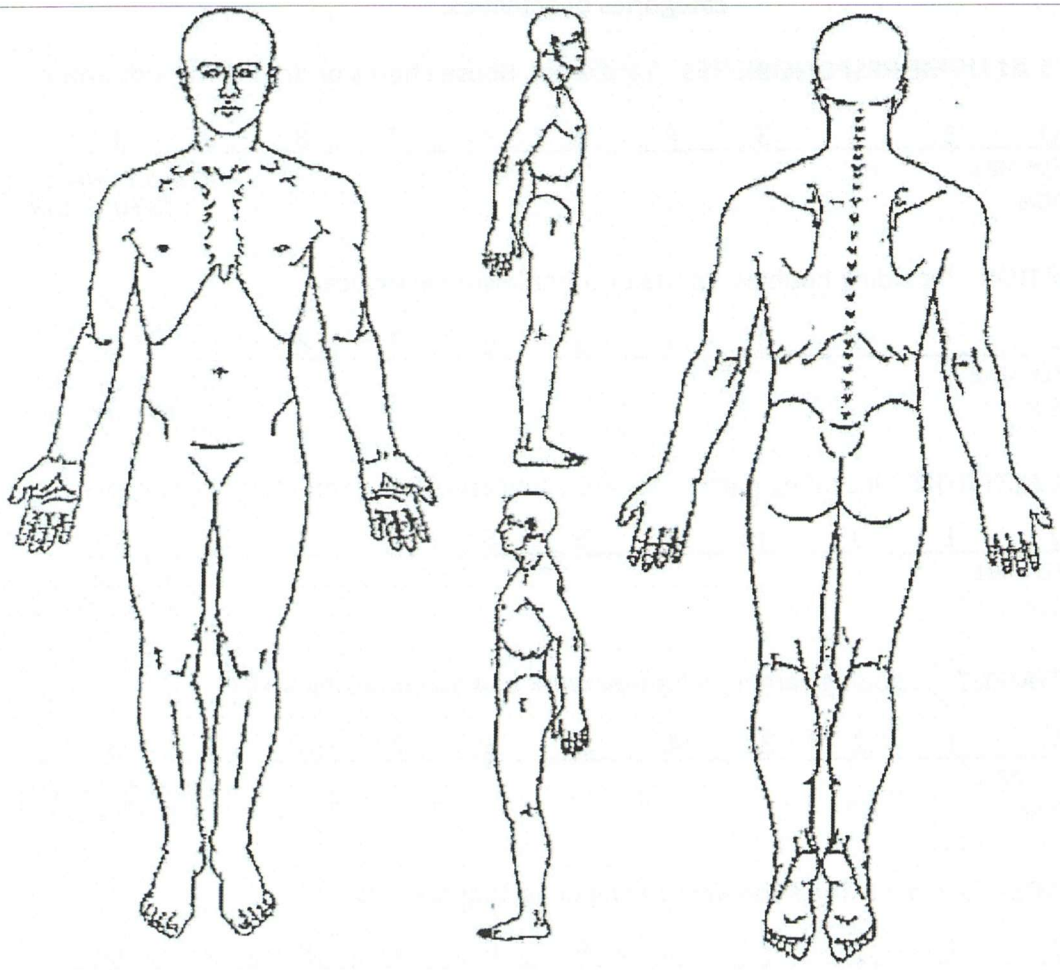
PAIN DISABILITY INDEX QUESTIONNAIRE

Name: _____ Date: _____

On the diagram below, please indicate where you are experiencing any pain at this time. Use the code at the bottom to describe your pain. Please complete both sides of this form.



A = ACHE	B = BURNING	N =NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

Have you had testing or been treated by another professional for this same condition? ☐ Yes ☐ No

If so, which tests?_____ Doctor's Name/Facility:_____

Name of your Primary Care Physician: _____PCP Office Phone #: _____

We will be sharing your treatment information with the PCP listed above unless indicated otherwise:

☐ Please Share ☐ I do NOT want you to share my treatment information with my Primary Care Physician

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General Pain Index Questionnaire

We would like to know how much your pain presently prevents you from doing what you would normally do. Respond to each category by indicating the overall impact your present pain has on your life; not just when the pain is at its worst.

Please mark the number which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY 1 AT HOME RESPONSIBILITES** - Yard work, house chores or driving the kids around:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** - Including hobbies, sports or other leisure activities:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** - Including parties, theater, concerts, dining out and social events:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** - Including career, volunteer work and homemaking tasks:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF-CARE** - Such as taking a shower, driving or getting dressed:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE- SUPPORTING ACTIVITIES** - Such as eating and sleeping:

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

Print Name: _____ Date: _____

Patient Signature: _____