Welcome to Health and Wellness Alternatives

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"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease." – Thomas Edison

Patient Demographics

Last Name: _____ First Name: _____ MI: _____

DOB: ___/___/_____ Gender: _____ SSN_____-_____-_____ Weight: _____ Height: _____

Marital Status: _____ Employment Status: _____ Job Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax Number: _____ Email: _____

Preferred Contact (*For Appointment Reminders*): (select one) ☐ Cell / ☐ Email

Employment Information

Employer Name: _____ Employer Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Contact Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance

Primary Insured ID: _____ Insurance Name: _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Patient Relationship to Primary Insured: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance Information (*if applicable*): _____

Symptoms (When checking in to your appt you will be able to be more specific with each individual body part)

Reason for Visit: _____ When Symptoms Began: _____

Is the condition getting worse? _____Where is problem located? (specific): _____

Which activities are difficult to perform?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Other _____

Type of Pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Severity of Pain (1=mild, 10=severe): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Is the pain constant? When does it occur? _____

What Treatment Have You Already Received?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

Name/Contact Information For Doctor(s) Who Have Treated You For You Condition: _____

_____

Health History

Check Conditions Which Are Applicable:

- ☐ AIDS/HIV
- ☐ Vaginal Infections
- ☐ Herpes
- ☐ Miscarriage
- ☐ Breast Lump
- ☐ Suicide Attempt
- ☐ Depression
- ☐ Bulimia
- ☐ Alcoholism
- ☐ Anorexia
- ☐ Chemical Dependency
- ☐ Psychiatric Care
- ☐ Hernia
- ☐ Pacemaker
- ☐ Thyroid Problems
- ☐ Chicken Pox
- ☐ Herniated Disc
- ☐ Parkinson's Disease
- ☐ Tonsillitis
- ☐ Anemia
- ☐ Pinched Nerve
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Mumps
- ☐ High Cholesterol
- ☐ Pneumonia
- ☐ Tumors, Growths
- ☐ Appendicitis
- ☐ Emphysema
- ☐ Kidney Disease
- ☐ Polio
- ☐ Typhoid Fever
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Liver Disease
- ☐ Prostate Problems
- ☐ Ulcers
- ☐ Asthma
- ☐ Fractures
- ☐ Measles
- ☐ Prosthesis
- ☐ Bleeding Disorders
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Migraine/ Headaches
- ☐ Venereal Disease
- ☐ Allergy Shots
- ☐ Cataracts
- ☐ Goiter
- ☐ Rheumatoid Arthritis
- ☐ Whooping Cough
- ☐ Bronchitis
- ☐ Gout
- ☐ Mononucleosis
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Multiple Sclerosis
- ☐ Cancer
- ☐ Stroke
- ☐ Scarlet Fever

Other: _____

Date of Last Health Exam: __/__/_____ Surgeries You Have Had/Dates They Occurred: _____

_____

All medications Currently taking: _____ Allergies: _____

Women~ Are You Pregnant? ☐ Y / ☐ N Nursing? ☐ Y / ☐ N Taking Birth Control? ☐ Y / ☐ N

Daily Habits

Level of Daily exercise? ☐ None ☐ Moderate ☐ Heavy Specify:_____

Vitamins/ Nutritional Supplements? _____ Do You Smoke? If So, How Much? _____

How Much Liquor do You Consume Daily? _____ Coffee/Caffeinated Beverages Daily? _____

Authorization

I certify that I have read and understand the above information and have accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (Or Parent If A Minor):

X_____ **DATE** _____

INFORMED CONSENT

I, the undersigned, have voluntarily requested that the doctor assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that the doctor is a chiropractor and that her services are not to be construed or serve as a substitute for standard medical care. The doctor recommends that I undergo routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.

Routine chiropractic examination and treatment involve some of the following methods:

- Observation: General assessment/appraisal in all postures.
- Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) body parts may be viewed. Women may continue wearing their bra in the course of the examination unless it obscures visualization/viewing of injured/abnormal body parts. You may request an observer be present at any time during the examination and/or treatment.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: Using a rubber hammer and tapping on bones or tendons
- Orthopedic/neurological testing: These are standard tests to assess your neuro-musculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment

Soreness: I am aware that like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform Dr. Flores if you experience these symptoms.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasms. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of the injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible never damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation, but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to the Informed Consent document.

_____ _____

Patient's Signature **Date**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:_____

Signature: _____ Date: _____

PAYMENT POLICY

Thank you for choosing Health and Wellness Alternatives. We are committed to providing you with quality and affordable health care. We hope that we will not be forced to pass these costs on to you but in order to keep our costs down, we must have your full cooperation. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- **Insurance.** We participate in most PPO insurance plans, including Medicare. We will verify and submit your insurance claims for you as a courtesy service; however, the **benefits quoted are not a guarantee of payment**. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card/member ID number, payment in full for each visit is required until we can verify your coverage. If your insurance does not pay your bills in a timely matter, the clinic may require future treatment to be paid for at the time of service. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Sometimes, an insurance company will contact you for more information. Insurances may request proof that someone is a legal dependent or if you do/do not have secondary insurance, and they will not pay for anything until you provide them with proof. You must send them the information or call them quickly. Many times insurance will refuse to pay the claim if you do not send them the requested information.
- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
- **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
- **Assignment of benefits.** If your insurance does not accept the assignment of benefits (for payment to be sent to the provider) you will be responsible to reimburse the clinic 'Health and Wellness Alternatives' the full amount paid by your insurance unless otherwise agreed on.
- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Thank you for understanding our payment policy. In the event any balance due hereafter is not paid as agreed, the undersigned jointly and severally agree to pay all costs incurred in said and unpaid balance, including reasonable attorney's fees.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature of Responsible Party	Print Name	Date