CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please don't hesitate to ask.

Name: _____

Birthday: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

You will be added to our email newsletter unless otherwise requested.

Home: _____ Cell: _____

Would you like to receive appointment reminders via text message? _____Yes/ _____ No

Marital Status: ____ M ____ S ____ D ____ W Driver's License #_____

Your Occupation: _____ Employer:_____

Phone #: _____ Address: _____

Is your visit due to an accident? _____ Yes / _____ No

Spouses Name: _____

Spouses Employer: _____ Spouses Work #: _____

Name of person to contact in case of emergency: _____

Emergency Contact Phone #: _____

Emergency Contact Work #: _____

Name of nearest relative not living with you: _____

Nearest Relative Phone #: _____

How did you hear about Pyramid Chiropractic? _____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patient Signature: _____ Date: _____

Parent or Guardian: _____

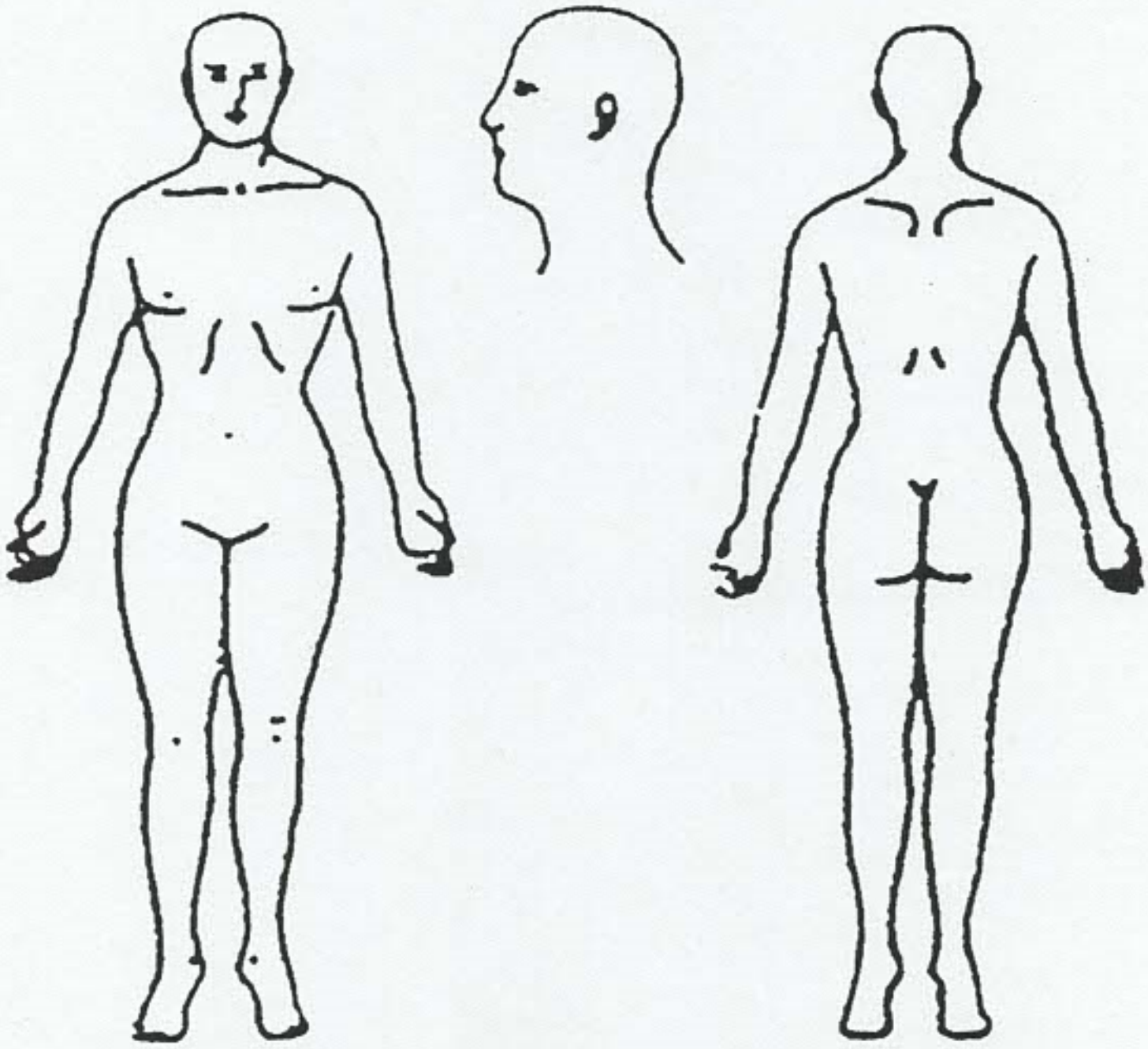
Signature: _____ Date: _____

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Reference: Randsford. Spine, Vol. 1, No 2, June 1976

FORM 504

PAIN SCALE

Name: _____ Date: _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

EXAMPLE: **0 = No Pain** **10 = Excruciating Pain**

HEADACHE NECK LOWBACK

0 1 (2) 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you DO NOT have insurance;** all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you DO have insurance;** all deductibles and co-payment are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget. We are NOT a Medicare participating provider. We offer senior citizen discounts, making care an affordable option at our clinic.

3. **Pyramid Chiropractic has a 24 hour cancellation policy. Full charges may apply when the office is not notified within 24hours of your scheduled appointment. The doctor's discretion will be used for each specific situation.**

You are considered a cash patient until you bring in your completed insurance forms and we qualify and accept your insurance coverage. We DO NOT accept assignment for secondary insurance carriers. **We do not accept Medicare.**

Our fees are considered usual, customary and reasonable by most insurance companies and therefore are covered up to the maximum allowance determined by each insurance carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, baring no relationship to the current standard of care in this geographical area.

If your carrier has not paid a claim within (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us, Pyramid Chiropractic to use your credit card to collect full payment. Charges for services rendered will be due as they are rendered, or by an authorized payment plan. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Discontinued care will result in a pro-rated refund for those who have prepaid treatments.

Patient's Printed Name: _____

Signature: _____ Date:_____

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as it appears on card: _____

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic and/or licensed physical therapists who may be employed by or engaged in practice at this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctors to choose and recommend a best course of treatment based upon known facts that are in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes and strain/sprains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. (For x-ray purposes, if needed).

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information
("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to Pyramid Chiropractic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment or health care operations and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or healthcare operations, and that I can also revoke this consent in, but only to the extent that the office has not taken action in reliance thereon and also providing that I do so in writing.

I understand that for my protection any requests to amend my health information or to access my medical records must be made in writing.

Patient's Name: _____

Signature: _____ Date: _____