Doholis Chiropractic Confidential Patient Information

Date ____________________ SS# ____________________

Name ____________________ Phone # ____________________

Local Address ____________________ City/State/Zip ____________________

Other Address ____________________ City/State/Zip ____________________

Age ________ Birth Date ____ / ____ / ____ Marital Status: S M W D How Many Children ____________

Occupation ____________________ Employer____________________ Work Phone# ____________________

Work Address____________________ City/State/Zip ____________________

Name of Spouse ____________________ Occupation ____________________ Employer____________________

Work Address____________________ City/State/Zip ____________________ Phone# ____________________

Who referred you to our office?____________________

List present complaints, injuries and duration and when specifically the symptoms or pain began:

1. ____________________

____

2. ____________________

____

Brief remarks and details of any recent related accident:

____

____

____

____

Are your symptoms:

❑ getting worse, ❑ getting better, or ❑ staying the same?

List any doctors consulted for present complaints and injuries:

Name ____________________ Specialty ____________________

Address ____________________

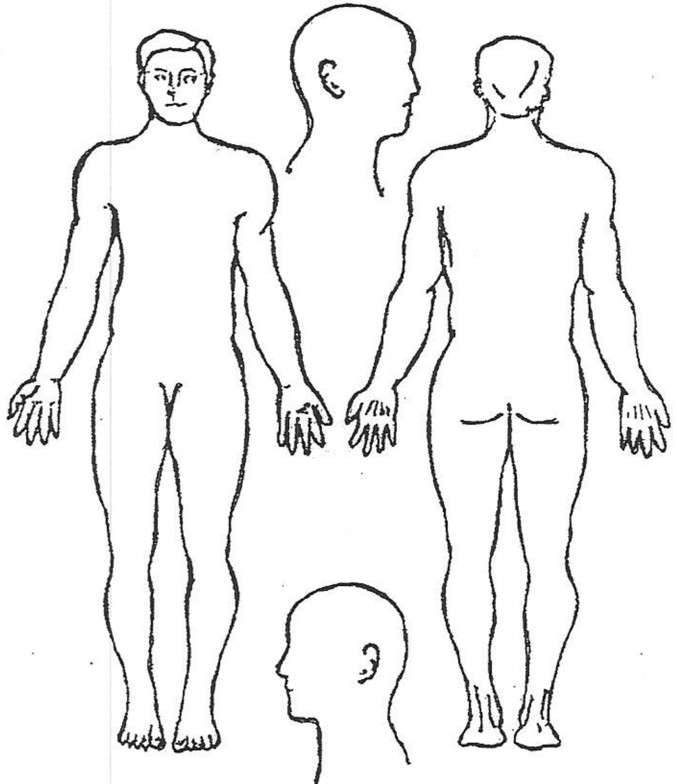
Consulted from ____________________ to ____________________

Name ____________________ Specialty ____________________

Address ____________________

Consulted from ____________________ to ____________________

Please mark your areas of pain on the figures below:



0-----------------------------5-----------------------------10

How bad is your pain (0 being tolerable to 10 untolerable)

Doholis Chiropractic Patient Past Health History

What surgeries have you had and/or fractures or broken bones, etc.? (Type, When, Doctor, Remarks)

____

____

List former serious accidents, injuries and/or falls: (Auto, Work, Home, Leisure, Other) (What, When, Symptoms, Treatment, Results)

____

____

List medications and/or diet supplements you take: (What, Frequency, Doctor(s), Side Effects, How Long Taken, Remarks)

____

____

Do you wear orthotics, heel or sole lifts, in your shoes? ______________________

Occupational (Please circle appropriate answer and give details below)

I Spend the Day — Seated / Standing Work Bench / Desk Counter / Other:

Job Involves — Lifting (how much) ____ / Bending / Stooping / Twisting / Turning / Carrying / Walking / Standing / Other

Chair — Executive / Steno / Bench / Stool / Folding / Other______________________

Shoes — High Heels / Boots / Other______________________

Do any work activities aggravate your present main complaints? Describe: ______________________

Comments: ______________________

____

Leisure

Sedentary Activities — TV / Reading / Card Games / Sewing / Other (circle all applicable and describe how long) ____________

____

Strenuous Activities — Sports / Exercise (type, frequency, length of time) Have you had to discontinue any activities? ________

Describe:____

How would you grade your general stress level? ❑ No Stress ❑ Minimal Stress ❑ Moderate Stress ❑ Greatly Stressed
Physical activity at work: ❑ Sedentary more than 50% of workday ❑ Light manual labor ❑ Manual labor ❑ Heavy manual labor
General physical activity: ❑ No regular program ❑ Light exercise program ❑ Strenuous exercise program

X-Ray Confirmation: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signed: ______________________

Consent to Treat a Minor Child: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed: ______________________ (Parent / Legal Guardian)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ______________________ Date: ____________

Guardian or Spouse's Signature: ______________________ Date: ____________

Information Taken By: ______________________ Date: ____________

Doholis Chiropractic Patient Information

Name: ______________________________ Date: ______________

Please check off any of the following symptoms you have experienced:

❑ Headaches	❑ Dizziness	❑ Light Bothers Eyes
❑ Neck Pain	❑ Head Seems Too Heavy	❑ Loss of Memory
❑ Neck Stiff	❑ Pins/Needles in Arms	❑ Ears Ring
❑ Sleeping Problems	❑ Pins/Needles in Legs	❑ Face Flushed
❑ Back Pain	❑ Numbness in Fingers	❑ Buzzing in Ears
❑ Nervousness	❑ Numbness in Toes	❑ Loss of Balance
❑ Tension	❑ Shortness of Breath	❑ Fainting
❑ Irritability	❑ Fatigue	❑ Loss of Smell
❑ Chest Pain	❑ Depression	❑ Loss of Taste
❑ Diarrhea	❑ Stomach Upset	❑ Fever
❑ Feet Cold	❑ Constipation	❑ ______________
❑ Hands Cold	❑ Cold Sweats	❑ ______________

1. Does this cause you to be:

- ❑ Moody
- ❑ Irritable
- ❑ Interrupt Sleep
- ❑ Restricted on Daily Activities

2. Does this affect your work:

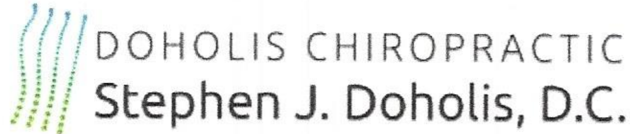
- ❑ Decision Making
- ❑ Poor Attitude
- ❑ Decreased Productivity
- ❑ Exhausted at End of Day
- ❑ Unable to Work Long Hours

3. Does this affect your life:

- ❑ Lose Patience with Spouse or Children
- ❑ Restricted Household Duties
- ❑ Hinders Ability to Exercise or Participate in Sports

A. How long have you noticed this? Weeks ______ Months ______ Years ______

B. Would you like to find out what could be causing your problem? ❑ Yes ❑ No



4531 N. 16th St. # 110

Phoenix, AZ. 85016

(602) 224-5141

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, n me (or on the patient named below from whom I am responsible) by Dr. Doholis, Chiropractor, and/or any licensed doctor or chiropractic associate with or working as a back-up for Dr. Doholis.

I understand that result of treatment 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 fracture, disc injuries, stokes, dislocations and strains. I do not expect the doctor to be able to anticipate and explain all 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 known, is in my best interest.

I have read, or had read to me, above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to above named procedures. This consent form is intended to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by patient or guardian/patient representative:

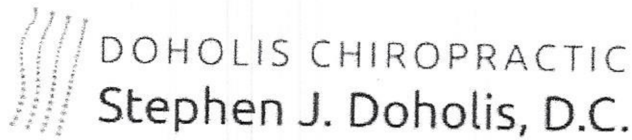
Print patient's name:____

Signature of patient:____

Date signed: ____

Print name of guardian or patient representative:____________________

Witnessed by: ____



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Regular Fee Schedule

As of August 1, 2018, our standard fee schedule, Fee for a "Brief to moderate" full spine evaluation and subsequent adjustment for established patients, at this office, or, known in the CPT coding as a"98941" is $70.00.

This does not cover the cost of the Initial New Patient Evaluation or a subsequent Re-Examination of an established patient for a new problem or complaint. Nor, does it cover the cost of X-rays or Therapy (any modalities or procedures /traction or hot packs etc.) or the cost of supplements purchased through this office, all of which have a specific separate fee.

Please check with the front desk to determine what the fee for which service is at an particular time, as fees may change for individual services or products at any time.)

Time of Service (TOS) Fee

As a courtesy to regular patients who wish to pay their account at the Time of Service, and receive a receipt for said services and/ or a Super-bill to do their own billing to their particular insurance company or managed care group,(and thereby helping reduce our office expenses) we will pass along a savings to you. That is to say, instead of charging our regular fees(an example noted above: 98941 = $70.00 being the regular fee) we will require you to pay only a **$45.00 fee** for the same said service. Further, all other therapy codes will be similarly reduced in fee percentage, such as for ultrasound therapy / EMS / traction or ice therapy in a similar percentage reduction. (our discretion)

Finally, should I or my third party 'payor' wish to nullify this agreement and wish Doholis Chiropractic to "bill" my third party 'payor,' all "regular fees" (without reduction) will prevail and all therapy also billed, will be billed at the higher regular fee schedule, and this "Time Of Service" agreement will become null and void.

____
Print name of patient

____
Date

____
Signed by patient

____
Witness

NOTICE OF PRIVACY POLICIES

This notice describes the health information about you that may be listed and disclosed, and how you can get access to your health information. This is a required Privacy Regulation resulting for the Health Insurance Portability Act of 1966 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information, and to provide a copy of this information to you.

We may use ans disclose your health information in the following ways:

1. Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. We may also disclose your health information to others who may assist you in your care, such as spouse, parents, and children.
2. Our practice may use your health information to bill and collect payments, including your insurer or any third parties that may be responsible for such costs. We may also use your health information to bill you directly for services and items.
3. Our practice will use and disclose your health information if we are required by law.
4. We may call you for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, answering machine or with co-workers at you place of work. We may also use a sign-in-sheet at our front desk. We will make all efforts to keep this information confidential.

Your rights concerning your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner. We will do our best to accommodate all reasonable requests.
2. You can request that we restrict our use of your health information for treatment, payment or health care operations, as well as the release of this information only to certain individuals. We are not however, required to agree to your records in some circumstance.
3. You have the right to inspect and obtain a copy of your medical and billing records. You must submit your records in writing to your physician. You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment, you must supply us with a reason to support your request.
4. If you believe your privacy rights have been violated you may file a complaint with our office or with the Secretary of the Department of Health & Human Services. To file a complaint with our practice or if you have any questions about this policy notice, please contact your physician's secretary at (602)244-5141.

We have supplied you with our Notice of Privacy Practice. You will be asked to place your signature in your chart indicating that you have read, understood and agreed to this policy. A copy of this policy may be obtained from the receptionist at the front desk.

PATIENT SIGNATURE ________________________ DATE: ______________

WITNESS: ________________________________ DATE: ______________