Volz Family Chiropractic

1995 N Cedar St Suite #3, Holt, MI 48842
Phone # (517) 699-3000

Name:	Nickname:	Marital Status: Single / Mar / Div / Sep / Widow	Case #: 1st Appt: 2nd Appt:	
Email:		Birth date:	Age:	Sex:
Address:	City:	State:		
Zip Code:	SS#:	Home Phone:		
Cell Phone:	Are you a college student: ☐ No ☐ Yes	Number of Children:		
Occupation:	Employer:	Work phone:		

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor: Date of last visit:

Have you seen a Chiropractor before?: ☐ No ☐ Yes, Name of Chiropractor: Date of last visit:

Have you had any surgeries?: ☐ Yes ☐ No If yes, please provide detailed information below:

Surgery:	Date performed:	Reason for Surgery:
Surgery:	Date performed:	Reason for Surgery:
Surgery:	Date performed:	Reason for Surgery:

List any Supplements & Medications:

Height: **Weight:** **Pregnant?** ☐ Yes ☐ No ☐ **Left handed** ☐ **Right handed**

Past & Present illness or Conditions:

☐ Allergies	☐ Blood Clots/ Embolism	☐ Ear Infections	☐ Hernia	☐ Multiple Sclerosis	☐ Scoliosis
☐ Angina/ Heart Attack	☐ Cancer	☐ Epilepsy/ Seizures	☐ High/Low Blood Pressure	☐ Night Sweats	☐ Sinus Problems
☐ Arthritis	☐ Constipation/ Diarrhea	☐ Fainting	☐ HIV/AIDS	☐ Osteoporosis	☐ Stroke/TIA
☐ Asthma	☐ Diabetes	☐ Fatigue	☐ Indigestion	☐ Pacemaker	☐ Ulcers
☐ Autoimmune Disease	☐ Disc Problems	☐ Headaches/ Migraines	☐ Menstrual Problems (PMS)	☐ Prostate trouble	☐ Unable to Sleep
☐ Bedwetting	☐ Dizziness/ Vertigo	☐ Hearing Trouble	☐ Mental/ Emotional Difficulty	☐ Rheumatoid Arthritis	☐ Other _____

Family History of illness:

☐ Alzheimer's	☐ Autoimmune Disease	☐ Diabetes	☐ Multiple Sclerosis	☐ Parkinson's	☐ Stroke/TIA
☐ Arthritis	☐ Cancer	☐ Heart Problems	☐ Osteoporosis	☐ Spinal Disc Disease	☐ Other _____

Have you ever had any significant falls, accidents or injuries?

Sleep Position: ☐ Back ☐ Stomach ☐ Side **Stress:** ☐ None ☐ Mild ☐ Moderate ☐ Severe

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Light / Moderate / Strenuous Hours per week?	Recreational Drug Use? ☐ No ☐ Yes If so, what?

How did you hear about us? ☐ Friend/Family ☐ Website ☐ Ins. Co. ☐ Drive By ☐ Phonebook ☐ Other _____

Signature: _____ Date: _____

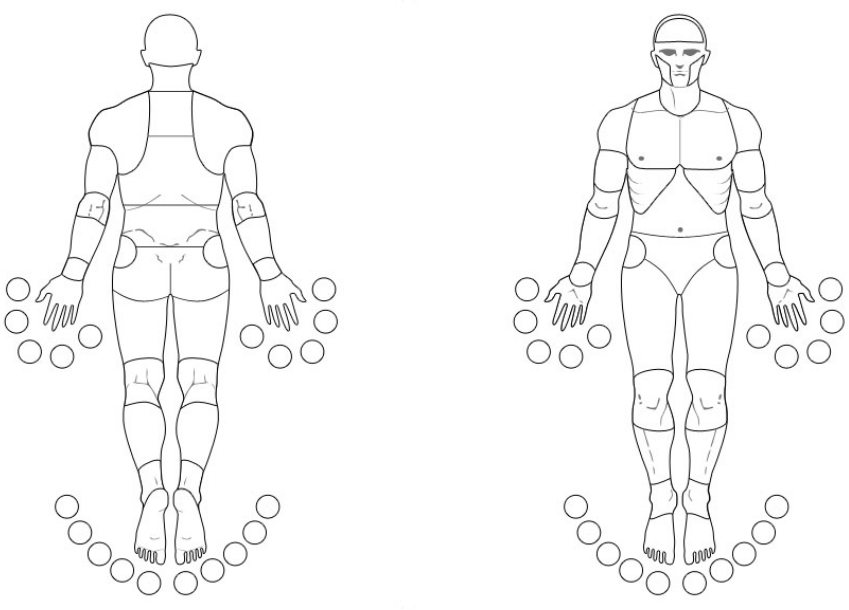
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CURRENT COMPLAINTS

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint	
Onset	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Description	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Shooting
Severity	☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bending ☐ Twisting ☐ Lifting ☐ Working ☐ Driving ☐ Housework ☐ Lying down ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Range of motion ☐ Pushing/pulling ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	
Does it interfere with	☐ Work ☐ Sleep ☐ Daily routine ☐ Other
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Comments	

Area of Complaint	
Onset	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Description	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Shooting
Severity	☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bending ☐ Twisting ☐ Lifting ☐ Working ☐ Driving ☐ Housework ☐ Lying down ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Range of motion ☐ Pushing/pulling ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	
Does it interfere with	☐ Work ☐ Sleep ☐ Daily routine ☐ Other
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Comments	

Area of Complaint	
Onset	
Location	☐ Left ☐ Right ☐ Both ☐ Center
Pain Ratings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency	☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain Description	☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Shooting
Severity	☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?	☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?	☐ Bending ☐ Twisting ☐ Lifting ☐ Working ☐ Driving ☐ Housework ☐ Lying down ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Range of motion ☐ Pushing/pulling ☐ Bright lights ☐ Loud Noises
Does the pain radiate to any other locations?	
Does it interfere with	☐ Work ☐ Sleep ☐ Daily routine ☐ Other
At it's worst	☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Comments	

_____

Patient's Signature

Volz Family CHIROPRACTIC PLLC

1995 N. Cedar Street, Suite #3
Holt, MI 48842
Phone #: (517) 699-3000
Fax #: (517) 699-3610
www.volzchiro.com

HIPAA Privacy Papers

I received a summary of the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to this office.

The full disclosure forms are available in the waiting room.

_____
Print PATIENT Name

_____
Patient Signature

_____
If patient is a MINOR, Signature of Parent or Legal Guardian

_____
Date

Volz Family Chiropractic

PATIENT CONSENT

CONSENT FOR CARE:

I voluntarily consent to the rendering of care, including care and performance of procedures. I understand that I am under the care and supervision of the attending Chiropractor and it is the responsibility of the staff to carry out the instructions of the Doctor of Chiropractic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results 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 fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **Volz Family Chiropractic** to use and disclose protected health information for the purposes of care, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (517) 699-3000. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of care, payment or health care operations. We are not required by laws to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

RELEASE OF X-RAYS FOR RADIOLOGIST

By signing this form, I authorize the release of x-rays and medical information necessary to SAFEGAURD Radiology for interpretation of my diagnostic imaging studies. I request payment of benefits for this service to the party who accepts assignment,Volz Family Chiropractic.

VERIFICATION OF PREGNANCY / NON-PREGNANCY (Female Patients Only):

I do hereby state to the best of my knowledge, I am pregnant, or pregnancy is suspected. Due Date _____.

OR

I do hereby state to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature or Signature of Parent or Legal Gaurdian Witness

Volz Family CHIROPRACTIC PLLC

1995 N. Cedar Street, Suite #3
Holt, MI 48842
Phone #: (517) 699-3000
Fax #: (517) 699-3610
www.volzchiro.com

OFFICE, FINANCIAL AND CANCELLATION POLICIES

Thank you for choosing our office to meet your Chiropractic healthcare needs. It is our optimal goal to provide you and your family with the highest quality of chiropractic care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your chiropractic needs, we ask you to please observe the following guidelines.

Office and Financial Policies

- We require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, Mastercard, American Express and Discover.
- We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your chiropractic health care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic benefits before your care begins by calling your insurance company, as you are ultimately responsible for any of the monies not covered by your insurance.
- ***Your personal balance may not exceed $100 at any time or your care may be terminated.***

Cancellation Policy

- The office requires a minimum of 24 hours notice if an appointment must be rescheduled. If less than 24 hours notice has been given a $25 fee will be assessed. In the event that no notice is given and the patient does not show up for their appointment, then a $45 fee will be assessed. Special circumstances will be taken under consideration. Please note that this fee is not covered by insurance and payment is the patient's responsibility.

I accept full financial responsibility for expenses incurred at Volz Family Chiropractic PLLC.

I accept full financial responsibility for failures on my part to provide or know my insurance benefits information at the time services are rendered.

I have read and understand the above conditions.

_____ _____

Patient's Name (Please Print) Date

_____

Signature of Responsible Party

Volz Family CHIROPRACTIC PLLC

1995 N. Cedar Street, Suite #3
Holt, MI 48842
Phone #: (517) 699-3000
Fax #: (517) 699-3610

TO OUR PATIENTS

There are over 1000 insurance plans in America. Therefore, it is IMPOSSIBLE for our office to know the covered benefits of YOUR insurance plan. As a courtesy, we try to verify what coverage you may have to inform you of your benefits before starting care. However, it is the RESPONSIBILITY of the PATIENT to know and understand the policies and benefits of their insurance plan. These include but are not limited to:

1. Required referrals obtained and presented PRIOR to services being rendered.
2. Deductibles, Co-payments and Co-insurances as they are different.
3. Covered exams, re-exams, x-rays, spinal manipulations (aka adjustments), mechanical traction, and massage therapy
4. Necessary prior authorization for procedures (MRI, CT) or specialists
5. Current claim address and phone numbers

SHOULD YOU HAVE ANY QUESTIONS REGARDING YOUR BENEFITS YOU WILL NEED TO CONTACT YOUR INSURANCE COMPANY. THE NUMBER TO REACH CUSTOMER SERVICE IS USUALLY PRINTED ON YOUR INSURANCE CARD OR MAY BE OBTAINED FROM YOUR HUMAN RESOURCES DEPARTMENT OR A PREVIOUS EXPLANATION OF BENEFITS!

_____ _____

Patient Signature Date