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:
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List any Supplements & Medications & dose:

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?	Cigarettes?	Caffeine?	Exercise? ☐ No ☐ Yes	Recreational Drug Use?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	Light / Moderate / Strenuous	☐ No ☐ Yes
Drinks per week?	Packs per day?	Drinks per day?	Hours per week?	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.

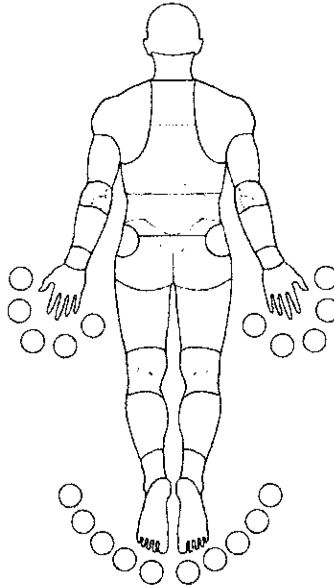
MH-0001

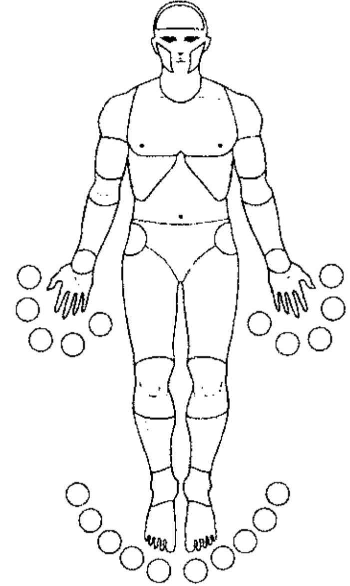
CURRENT COMPLAINTS

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. *Please use one section per complaint.*

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	

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Comments	

Patient's Signature

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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 $35 fee will be assessed. In the event that no notice is given and the patient does not show up for their appointment, then a $55 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

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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

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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

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 Guardian — Witness

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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 at the front desk.

____
Print PATIENT Name

____
Patient Signature

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

____
Date

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for care or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

MARKETING AUTHORIZATION

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your Chiropractor and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from Volz Family Chiropractic to you. We are specifically requesting authorization to market the following products and/or services to you – from time to time we will mail you reminders about the importance of real Chiropractic care, we may take pictures of our patients which we use on our website, in newspaper articles or newsletters, and with individual permission, we send birthday cards which may offer complementary services to our patients.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest and of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

Confidential Communication Request

From time to time in caring for our patients, it may become necessary to contact you by telephone. When you are not available for us to speak to directly, we like to leave messages when possible.

In order to protect your privacy, we have developed a policy on leaving messages.

- We will not discuss any medical or financial information with anyone except the patient or legal guardian.
- We will not leave any medical or financial information on any answering machine or voicemail system.
- We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment when the patient has opted out of text or email reminders.

UNLESS

We have your written permission to leave a message for you. Please read the information below and consider carefully whom you want to have access to your medical and financial information. Please check the box and fill out only ONE of the following sections below to make your preference known. This will remain in effect until you rescind it in writing.

☐ A. I **DO** CONSENT TO LEAVE DETAILED MESSAGES:

I, ____, give permission to Volz Family Chiropractic, PLLC and their staff to leave phone messages regarding my medical care and/or financial status with the following:

Please initial each one you wish to have your message left at.

My cell phone or home phone answering system ________ Ph # ____________________

My work voice mail ______________________________ Ph # ____________________

My spouse (name) ______________________________ Ph # ____________________

Other (name) __________________________________ Ph # ____________________

☐ B. I **DO NOT** CONSENT TO LEAVE DETAILED MESSAGES:

I, ____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care and/or financial status to be left on an answering machine, voice mail or with others.

Signature: ______________________________ Date: ____________________