

Welcome to

Active Health & Wellness

Date: _____

•remove obstacles •restore function •improve performance •maximize potential

HEALTH PROFILE

As a full spectrum Wellness office, we focus on your ability to be healthy. Our goals are; first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health. In most cases the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Name: _____ Nickname: _____ Age: _____ Referred By: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Work/Cell: (____) _____ Male: _____ Female: _____
 Single: _____ Married: _____ Divorced: _____ Birth Date: _____ Social Security #: _____
 Employer: _____ Individual Responsible for Account: _____ No. of children: _____
 Primary Care Physician: _____ Emergency Contact/Number: _____
 Email: _____ Spouse's Name: _____

Please present your insurance card to the front desk. Insurance Co. _____
 Insured (leave blank if same) _____ Employer _____ DOB ____/____/____
 SSN ____-____-____ Phone (____) ____-____ Address _____ City _____ St _____ ZIP _____

Assignment of Benefits, Authorization for Release of Information, and Consent

- Assignment of Benefits:** I hereby direct my insurance carrier(s) or attorney to pay by check made and mailed directly to: **Active Chiropractic, PC, 1521 E Boise Ave, Boise, ID 83706**
- I also understand that I am personally responsible and agree to pay, in a current manner, any balance due after payment or non-payment by my insurance carrier(s) or attorney.
- Authorization for Release of Information:** I hereby authorize the release of any pertinent information to any doctor, insurance company, adjuster, or attorney involved in this claim.
- A photocopy of this "Assignment of Benefits" and "Authorization for Release of information" shall be considered as effective and valid as the original.
- Consent:** I give permission to the doctor and his staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of the named patient.

Patient/Guardian Signature: _____

I have read and agree to the above statements

Medical History

Major Complaint: _____

Check all that apply	Past	Now	Family
Heart Disease			
High Cholesterol/Lipids			
High Blood Pressure			
Digestive Disorders (bowels)			
Cancer			
Thyroid Disease			
Kidney Disease			
Liver Disease			
Diabetes			
Arthritis/Painful Joints			

	Past	Now	Family
Blood Clotting Problems			
Hormonal/Menstrual issues			
Headache(migraine/tension)			
Sleeping Problems			
Stomach Disorders (GERD)			
Emotional (Depression)			
Irritability/Anxiety			
Neck Pain			
Back Pain			
Loss of Balance			

List any conditions not found above about yourself or your family: _____

Medical History continued

Other Doctors seen for this problem (please list)

- Chiropractor (have you ever been/for what problem?) _____
- Medical Doctor _____
- Other _____

List any surgeries and/or accidents and the dates: _____

List Vitamins, Minerals, and Herbal supplements taken: _____

List any medications both prescribed and over the counter (OTC) you use regularly or occasionally: _____

List any known or suspected allergies: _____

Please circle if you are wearing: **heel lifts** **sole lifts** **inner soles** **arch supports** **other** _____

Frequency	Alcohol	Coffee	Tobacco	Exercise	Sleep	Appetite	Sweets
None	Never	Never	Never	Never	1-3hrs	Never hungry	Never
Light	1-2x wk	1-2x wk	Occasional	1-2x wk	3-5 hrs	Skip meals	Occasional
Moderate	3-4x wk	3-4x wk	Daily	3-4x wk	5-8 hrs	3+ meals/snack	Daily
Heavy	5-7x wk	5-7x wk	Multi-daily	5-7x wk	8+ hrs	Always hungry	Multi-daily

On a scale of Poor, Good, or Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Comments: _____

On a scale of 1 – 10 (1 = none /10 =Extreme) describe your stress level: Occupational _____ Personal _____

What is your Health Philosophy? (What should you do to be healthy?) _____

How do you want us to handle your condition/problem?

- ___ Temporary Correction (correct symptoms)
- ___ Maximum Restoration (correct cause of symptoms)

What are your expectations of us? _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

- Children _____
- Spouse _____
- Mother _____
- Father _____
- Brothers _____
- Sisters _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature / Date

Active Health and Wellness Financial Agreement

Dear Patient:

Active Health and Wellness will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Active Health and Wellness.

We wish to make it very clear that your health is your sole responsibility.

These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I choose the following method of payment for my care at Active Health and Wellness:

_____ **CASH** - Payment is due at the time of services. All patients who wish to file their own insurance may receive the same cash price by paying for the service at the time of the service and waiting for reimbursement from their insurance company.

_____ **MEDICARE** - Payment for co-pays and deductibles is due at time of service.

_____ **WORKERS COMPENSATION** - My employer has agreed to pay for the services rendered by Active Health and Wellness. I understand that I am responsible for any portion of this bill that my employer or their insurance carriers may refuse to pay.

_____ **PERSONAL INJURY** – We will file your claim with the appropriate insurance carrier (**your** health insurance and/or auto med-pay), and the third party carrier (other person’s insurance) as you are treated and file a Physician’s Lien to assure payment. The third party carrier will not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree **not** to allow your attorney to reduce our fees for their/your profit. When released, a 90 day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/terminated care without your doctor’s approval, the balance of your account is due immediately.

_____ **INSURANCE POLICY COVERAGE** – Group insurance is an agreement between you and your insurance company, not between your insurance company and your doctor. As a courtesy to our patients, our office will complete and file your claims on standard forms at no charge. We are credentialed by most insurance plans. The amount they pay varies from one policy to another. Because of the difference between policies, we request that each patient pay the deductible, percentage, and/or co-pay as stated in your policy.

_____ **CARE CREDIT** – Upon approval from care credit I will pay for each visit using the care credit card or in advance for a series of treatments.

NOTE: Active Health and Wellness will refund or apply to future services any overpayments made by patient at patients option.

Responsible Party Name (*print*) _____ Date: _____

Responsible Party Signature: _____

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We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential Communications
- Amend your protected health information

These privacy practices are effective: 10/01/2006

For further information please contact: Office Manager

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

Patient or guardian signature

Date

Active Health and Wellness Patient Disclaimers

PATIENT X-RAY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation have been explained to my satisfaction. I understand the clinical necessity for having x-rays taken at this time and grant my permission for this procedure. In so doing, I release the Doctor and Active Health and Wellness from responsibility of potential damage arising from this procedure.

Signature of Patient

Date

PATIENT BODY COMPOSITION DISCLAIMER

My signature below acknowledges that I am not pregnant and do not have a pacemaker or any electrical implants. I understand that this procedure sends a low, safe electrical current through my body and I release the Doctor and Active Health and Wellness from responsibility of potential damage arising from this procedure.

Signature of Patient

Date

Weight Management Profile

Weight History:

At what age did you first have trouble with weight? _____

What was your highest weight and at what age? _____

What was your lowest adult weight and at what age? _____

What do you consider to be barriers to weight loss? _____

For Females Only:

How many pregnancies have you had? _____ How many children? _____

Have you undergone hysterectomy or removal of ovaries? If yes, what was the reason for surgery and date?

When was your last menstrual period? _____ How many days did it last? _____

Do you ever have irregular cycles or abnormal cycles? _____

What are the previous diets/weight loss plans you have tried?

Name: _____ Dates: _____ Weight loss: _____ Reason for failure: _____

Current Medical Concerns and Review of Systems:

Please check the category that best applies to you:

	Absent	Mild	Moderate	Severe
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/Irregular Menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Trouble/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Vaginal Spotting	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Difficulty Reaching Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Irregular/Irritable Bowels	_____	_____	_____	_____

Please list any other problems you are having today: _____
