DOCSPITZ PERFORMANCE CLINIC

PATIENT INFORMATION

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Domestic Partnership / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Name of Spouse	Home Phone: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work/Cell Phone: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give DocSpitz your insurance card to be copied.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ _____	❑ Anthem/BCBS	❑ Cigna/Great West	❑ UHC	❑ Medicare

Subscriber's name:		Birth date: / /	Group number	Policy number	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group number	Policy number

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone : ( )	Work/cell phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DOCSPITZ Peformance Clinic to release any information required to process my claims.

Patient/Guardian signature ***Date***

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Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.

2. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he feels at the time to be in my best interest.

3. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are *extremely* rare occurrences.

4. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.

5. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.

6. I understand that there are other forms of treatment available to me, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis.

Patient Signature _____ **Date** _____

DOCSPITZ PERFORMANCE CLINIC

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
- More information on PHI is available upon request.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Sign: _____ **Date**: _____

DOCSPITZ PERFORMANCE CLINIC

Medical History

In order to serve you best, it is important to have a *relevant* personal and family medical history.

Please circle and describe illnesses or symptoms that you have currently or have had in the past:

Arthritis:_____

Allergies: _____

Diabetes: _____

Genetic Disorders: _____

High/Low Blood Pressure: _____

Migraines: _____

Numbness: _____

Dizziness: _____

Blood Disease: _____

Cancer: _____

Epilepsy: _____

Heart Conditions: _____

Bone Fracture: _____

Fainting: _____

Systemic Disease:_____

Mental/Emotional difficulty: _____

Have you seen another Doctor for your current symptoms? Yes No

Name of Doctor:_____

What treatment did you receive and when? _____

Has anyone in your family been diagnosed for any of the above? _____

Have you had any surgeries? Yes No If yes, when: _____

Do you smoke cigarettes? Yes No If yes, how many per day? _____

Do you exercise regularly? Yes No How many hours per week? _____

Are you taking any medications? Yes No If yes, please list them: _____

_____

Please list any major hospital visits, car accidents or major injuries: _____

_____

Is there anything else that Dr. Spitzlberger should know about? Yes No

If yes, please explain: _____

Have you ever been to a chiropractor before? Yes No

What kind of treatment did you receive? _____

How did you respond to that treatment? _____