

## *Patient Application Form*

Welcome to Ultimate Health Chiropractic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is unique and more advanced than other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly. Feel free to ask any questions if you need assistance. We look forward to serving you.

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**Patient Name**

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**Patient Signature**

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**Today's Date**

# Patient Application

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Drivers Licence Number: \_\_\_\_\_  
How were you referred to this office?: \_\_\_\_\_  
Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Work Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ Spouse's Phone: \_\_\_\_\_

## PURPOSE OF THIS VISIT

Reason for this visit: \_\_\_\_\_  
Is it work or auto accident related?  Yes  No Describe: \_\_\_\_\_  
What activities aggravate your symptoms? \_\_\_\_\_  
Have you experienced this condition before?  Yes  No Who have you seen for this? \_\_\_\_\_  
What did they do? \_\_\_\_\_ How did you respond? \_\_\_\_\_  
Have you seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_

## HEALTH LIFESTYLE

Do you exercise?  Yes  No How often? \_\_\_\_\_ What activities? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ How much per week? \_\_\_\_\_  
Do you drink coffee? \_\_\_\_\_ How many cups per day? \_\_\_\_\_  
Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

## YOUR POSTURE DETERMINES YOUR HEALTH

Are you aware of any of your poor postural habits?  Yes  No Explain: \_\_\_\_\_  
Have you ever been told or feel like you carry your head forward?  Yes  No

## CERVICAL SPINE (NECK)

Postural distortions from subluxations (causing Forward Head Syndrome) in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience...?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck Pain                         | <input type="checkbox"/> Recurrent Colds/Flus | <input type="checkbox"/> Dizziness                       |
| <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Hearing Disturbances | <input type="checkbox"/> Allergies/Hay Fever             |
| <input type="checkbox"/> Sinus                             | <input type="checkbox"/> Coldness in Hands    | <input type="checkbox"/> Numbness/Tingling in Arms/Hands |
| <input type="checkbox"/> Pain in your Shoulders/Arms/Hands | <input type="checkbox"/> Low Energy/Fatigue   | <input type="checkbox"/> Visual Disturbances             |
| <input type="checkbox"/> Thyroid Conditions                | <input type="checkbox"/> TMJ/Pain/Clicking    | <input type="checkbox"/> Weakness in Grip                |

## THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- |   |   |
|---|---|
| <input type="checkbox"/> Heart Palpitations   | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs        | <input type="checkbox"/> Asthma/Wheezing                      |
| <input type="checkbox"/> Tachycardia          | <input type="checkbox"/> Shortness of Breath                  |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain on Deep Inspiration/Expiration  |

## THORACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- |   |  |
|---|--|
| <input type="checkbox"/> Mid Back Pain  | <input type="checkbox"/> Hypoglycemia            |
| <input type="checkbox"/> Reflux   | <input type="checkbox"/> Pain in your Ribs/Chest |
| <input type="checkbox"/> Tired/Irritable After Eating or when you Haven't Eaten for a While | <input type="checkbox"/> Nausea                  |
| <input type="checkbox"/> Indigestion/Heartburn  | <input type="checkbox"/> Ulcers/Gastritis        |

## LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- |  |  |
|--|--|
| <input type="checkbox"/> Low Back Pain                               | <input type="checkbox"/> Muscle Cramps in your Legs/Feet             |
| <input type="checkbox"/> Constipation/Diarrhea                       | <input type="checkbox"/> Pain into your Hips/Legs/Feet               |
| <input type="checkbox"/> Weakness/Injuries in your Hips/Knees/Ankles | <input type="checkbox"/> Menstrual Irregularities/Cramping (Females) |
| <input type="checkbox"/> Numbness/Tingling in your Legs/Feet         | <input type="checkbox"/> Recurrent Bladder Infections                |
| <input type="checkbox"/> Sexual Dysfunction                          | <input type="checkbox"/> Coldness in your Legs/Feet                  |
| <input type="checkbox"/> Frequent/Difficulty Urinating               |  |

List any health conditions not mentioned: \_\_\_\_\_

List any medications/surgeries: \_\_\_\_\_

List any trauma (falls, car accidents, etc.) \_\_\_\_\_

## AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The Doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## IN CASE OF EMERGENCY CALL

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



# Patient Financial Policy

We offer the following information to help you understand our financial policies and aid you in planning for payment. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and please ask if you have any questions about our fees, our policies or your responsibilities. We have outlined the following policies to improve the communication between our office and you, the patient.

## PAYMENT PROCEDURE

Our office requires PAYMENT AT THE TIME OF SERVICE unless the patient is covered by health insurance which pays to our office and this office has received VALID INSURANCE INFORMATION OR REFERRAL (when applicable). If you wish us to file your insurance for you, we will do so. CO-PAYMENT IS DUE AT THE TIME OF SERVICE. We accept payment by cash, check, credit card or CareCredit. CareCredit is our revolving monthly payment plan. Ask the front desk for details.

## NOTE

Our financial relationship is with YOU, not with your insurance company. When asked and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since insurance is an agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers.

## FEES

Our fees are usual and customary for this area in the chiropractic specialty. We invite you to discuss any questions you may have regarding our services or fees.

## COST OF COLLECTIONS

Upon default, you are responsible for attorneys' fees and/or cost of collections.

*I understand the Patient Financial Policy of Ultimate Health Chiropractic.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION OF RELEASE

I hereby authorize Ultimate Health Chiropractic to furnish any information concerning my treatment to insurance carriers, which is required to process insurance claims. I hereby accept responsibility for all fees regardless of insurance coverage.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE 04/14/2003.

## RIGHT TO NOTICE

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Ultimate Health Chiropractic can use your protected health information for treatment, payment and health care operations.

- a) Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- b) Payment: We may use or disclose your health information to obtain payment for services we provide you.
- c) Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

## YOUR AUTHORIZATION

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

## EMERGENCY SITUATIONS

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

## MARKETING

We will not use your health information for marketing communications without your written authorization.

## REQUIRED BY LAW

We may also use or disclose your health information when we are required to do so by law.

## ABUSE OR NEGLECT

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

## NATIONAL SECURITY

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

## APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

## YOUR RIGHTS AS A PATIENT

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.

- You have the right to amend your protected health information.
- You have the right to receive an account of disclosure of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

## LEGAL REQUIREMENTS

Ultimate Health Chiropractic is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to [www.uhchiro.com](http://www.uhchiro.com), or are available within our office.

## COMPLAINTS

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

## SHARING INFORMATION

If and when we believe it is necessary to share your protected information in any situation that is not included in the above paragraphs we will first seek special written permission.

### *Ultimate Health Chiropractic Privacy Policy Acknowledgement:*

I have received and read the Notice of Privacy Practices.

Patient Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Please email completed new patient applications to [myinfo@uhchiro.com](mailto:myinfo@uhchiro.com).

*\*You can also print the completed new patient application and bring it with you to your appointment.*