FIRM FOUNDATION
CHIROPRACTIC

Name:_____ **Date**:_____

Address:_____ **City/State/Zip**: _____

Home Phone:_____ **Work Phone**:_____ **Birth date**: _____

Sex: ☐ **Female** ☐ **Male** **SS#**_____/_____/_____ **Personal E-mail**: _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Your Employer Information **OK to call at work?** ☐ **YES** ☐ **NO**

Employer:_____ **Occupation**: _____

Address:_____ **City/State/Zip**: _____

WORK STATUS: ☐ **Full time** ☐ **Part time** ☐ **Disabled** ☐ **Student**

Spouse Information: **Name**: _____

Address:_____ **City/State/Zip**: _____

WorkPhone:_____ **Birth date**:_____ **SSN#**:_____

Spouse Employer Information

Employer:_____ **Occupation**: _____

Address:_____ **City/State/Zip**: _____

How did you hear about Dr. Davis? _____

Who is your primary care provider? _____

INSURANCE INFORMATION - ***Please provide your insurance card and driver's license when checking in:***
Who is responsible for this account? _____
Name of Insured: _____
Birth Date:_____ ***SS#***_____/_____/_____
Relationship to patient: ☐ ***Self*** ☐ ***Spouse*** ☐ ***Child*** ☐ ***Other***_____
Insurance Carrier:_____ ***Group Number:***_____

If under 18 years: I hereby grant permission for my child to receive treatment by Dr. Michael Davis or on-call colleagues:

ASSIGNMENT AND RELEASE:
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Michael Davis, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Davis may use my health care information and may disclose such information to the above named insurance company, or other company(ies) and their agents for the purpose of obtaining payment for related services. This consent will be ongoing.

Signature (Parent or Guardian's signature if under 18 years of age):_____

Printed Name: _____

Date_____ ***Relationship to patient:*** ☐ ***Self*** ☐ ***Spouse*** ☐ ***Child*** ☐ ***Other***_____

Reason For Your Visit - Please write down below anything that you want the doctor to know.

_____

_____

_____

Immediately following my last visit (if applicable) I felt: Better Same Worse

Since This Problem began I feel: Better Same Worse

Rate the Severity of Your Pain (If Any):

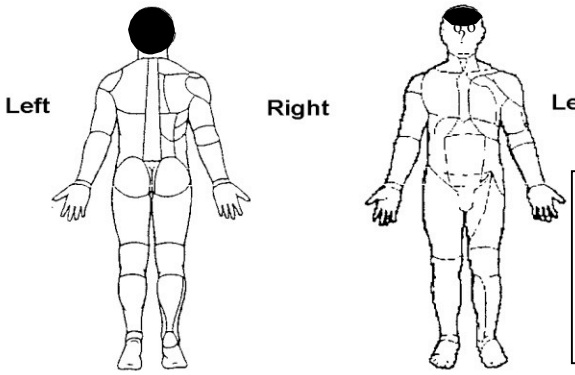
No Pain — Mild — Moderate — Severe — Pain as Bad as it Could Be

0 1 2 3 4 5 6 7 8 9 10

Describe the Pain or sensation

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



On the diagram to the left, please mark the areas where you are presently having a complaint.

When did your symptoms begin? _____

How often are symptoms present? Occasional Frequent Constant

It bothers me most when I _____

Pain intensity: 0)No pain 1)Mild pain 2)Moderate pain 3)Severe pain 4)Worst possible pain

Sleeping: 0)Perfect 1)Mildly disturbed 2)Moderately disturbed 3)Greatly disturbed 4)Totally disturbed

Personal care (washing, dressing, etc.): 0)No pain/no restrictions 1)Mild pain/no restrictions 2)Moderate pain/need to go slowly 3)Moderate pain/need some assistance 4)Severe pain/need 100% assistance

Travel (driving, flying, etc.): 0)No pain on long trips 1)Mild pain on long trips 2)Moderate pain on long trips 3)Moderate pain on short trips 4)Severe pain on short trips

Work: 0)Can do usual plus unlimited extra work 1)Can do usual /no extra 2)Can do 50% of usual 3)Can do 25% of usual 4)Cannot work

Recreation: 0)Can do all activities 1)Can do most activities 2)Can do some activities 3)Can do a few activities 4)Cannot do any activities

Frequency of pain: 0)No pain 1)Occasional pain 25% of the day 2)Intermittent pain 50% of the day 3)Frequent pain 75% of the day 4)Constant pain 100% of the day

Lifting: 0)No pain with heavy weight 1)Increased pain with heavy weight 2)Increased pain with moderate weight 3)Increased pain with light weight 4)Increased pain with any weight

Walking: 0)No pain any distance 1)Increased pain after one mile 2)Increased pain after one half-mile 3)Increased pain after one quarter-mile 4)Increased pain with all walking

Standing: 0)No pain after several hours 1)Increased pain after several hours 2)Increased pain after one hour 3)Increased pain after one half-hour 4)Increased pain with any standing

_____ Signature _____ Date

Name: _____ **Date:** _____

Is today's visit due to: ☐ Illness ☐ Accident ☐ Injury ☐ Other _____
Job related ☐ Yes ☐ No Automobile related? ☐ Yes ☐ No

How did your symptoms begin? _____

What activities *improve or relieve* your symptoms? _____

Medicine/supplements currently taking? _____

List past Surgeries/Injections: _____
Have you been treated for this condition before? ☐ Yes ☐ No If yes, by whom? _____
Are you *currently* under a healthcare provider's care for any other problems? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No ☐ Never Packs per day?_____How many years? _____
Do you use alcohol? ☐ Yes ☐ No ☐ Never Drinks per day?_____per week? _____
Do you use recreational drugs? ☐ Yes ☐ No ☐ Never How often? _____

CHRONIC ILLNESSES *(Check the disorders that you currently have) fill in type of condition on line next to illness*

- ☐ Alcoholism/Substance Abuse
- ☐ AIDS/HIV/ARC
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hayfever
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis_____
- ☐ Herpes _____
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mental Illness _____
- ☐ Migraine Headaches
- ☐ Miscarriages/Abortions
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke or TIA
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

PLEASE *CIRCLE* THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW OR *CHECK* NEXT TO CONDITIONS YOU PREVIOUSLY HAD.

General
Convulsions
Dizziness or fainting
Environmental allergies
Fatigue easily
Headaches
Loss of balance
Nerve pain
Nervousness or anxiety
Night sweats

Eyes-Ears-Nose-Throat
Deafness or hearing loss
Ear Discharge
Ear noises
Earache or ear pain
Eye infections
Eye pain
Frequent colds
Frequent sore throats
Nasal discharge
Nosebleeds
Sinus infections

Gastrointestinal
Abdominal distention
Constipation
Diarrhea
Food eruptions/reflux
Gallbladder trouble
Hemorrhoids
Irritable bowel syndrome
Liver problems
Spastic colons
Stomach pain
Ulcer disease

Genitourinary
Bedwetting
Blood in urine
Difficulty urinating
Frequent urination
Incontinence
Kidney infection/stones
Painful urination
Pus in urine
Sexual transmitted disease
_____
_____

Muscle/Joint
Arthritis/rheumatism
Bursitis
Foot trouble
Low back pain
Neck pain/stiffness
Pain between shoulders
Pain / numb / tingle in:
☐ elbows ☐ hands
☐ shoulders ☐ arms
☐ hip ☐ legs
☐ knees ☐ feet
Sciatica
Scoliosis
Swollen joints _____
Tremors
Weakness

Heart
Chest pain/angina
Hardening of the arteries
Heart attack
High blood pressure
Low blood pressure
Palpitations
Phlebitis
Poor circulation
Rapid heart beat
Rheumatic heart disease
Skipped heart beats
Slow heart beats
Swelling of ankles/legs

Respiratory
Asthma
Chronic cough
Difficulty breathing
Pain when breathing
Shortness of breath
Spitting up blood
Spitting up phlegm
Wheezing

***Women* only**
Breast lumps or pain
Excessive menstrual flow
Menopausal symptoms
Hot flashes
Irregular menstrual cycle
Menstrual cramps
Vaginal discharge

Skin
Acne
Easy bruising
Eczema
Hives
Rashes
Skin dryness
Skin oiliness
Varicose veins

***Men* only**
Impotence
Prostate

FIRM FOUNDATION
CHIROPRACTIC

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1997 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers-directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments.**

I have been informed by Firm Foundation Chiropractic Clinic of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice Of Privacy Practices (NPP) prior to signing this consent. I understand that the office of Dr. Michael Davis has the right to change its NPP from time to time and that I may contact them at any time at the address listed below to receive an updated copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME_____

SIGNATURE_____

DATE_____

Michael E. Davis D.C.

FIRM FOUNDATION
CHIROPRACTIC

DR. DAVIS' OFFICE FINANCIAL POLICY

NOTE: ALL PATIENTS MUST COMPLETE OUR ENTRY AND INSURANCE FORMS AND AGREE TO THIS FINANCIAL POLICY BEFORE SEEING DR. DAVIS.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. It is the goal of this office to provide quality care at a reasonable cost. By adhering to our policy, this can be achieved. Please understand that payment of your co-payments, deductibles, co-insurance or your entire bill must be made at the time of your treatment unless other arrangements have been made. The following is a statement of our Financial Policy, which we require that you read, and sign prior to treatment.

INSURANCE

This office accepts assignment for many indemnity insurance plans, HMO's and PPO's. Please refer to your policy for specifics on charges that are or are not covered. We may bill all insurance companies as a courtesy to you if current insurance information is provided. Your insurance policy is a contract between you and your insurance company. We are not a party to that (these) contract(s). If your insurance company or you have not paid for your services within **90 days,** an outside collection agency may be utilized. Monthly payments may be arranged. Please contact our office at **515-440-2005** regarding any questions on your billing between the hours of 8:00 a.m. and 3:30 p.m.

USUAL AND CUSTOMARY RATES

This office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Please help us serve all our patients better by keeping scheduled appointments. Missed appointments (more than 2) may result in a $75.00 charge to you, not your insurance carrier. If you find it necessary to cancel, please contact our office by phoning 515-440-2005. This charge can be avoided by canceling at least 8 hours in advance. Leaving a message with the answering service will satisfy this requirement.

INTEREST CHARGES

Your account will be charged interest at the rate of 1.5% per month, or 18% annually for balances over 60 days old.

SERVICE FEE ON RETURN CHECKS

A service fee of $30.00 or 5% of the face amount up to $50.00 will be charged on all returned checks. You may be sued for damages of three times the amount of the check, up to a maximum of $500.00 pursuant to Iowa codes 554.3512 & 554.3513. Return checks will be electronically re-deposited for the face amount and service fee. The service fee may also be collected by paper draft, CBSI Oskaloosa, Iowa or servicing agency.

I further authorize release of necessary medical records to my insurance carrier and direct payment to the provider of care. *In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.* I understand that 40% of the unpaid balance, representing the cost of collection, will be added if this account is turned over to a collection agency, and I agree to be held fully responsible for the sum thus due. I have read, understand and agree to the Financial Policy.

_____ Date_____

Signature of patient or legal guardian for person receiving care - Financial policy – 02/2/2011 revised