PATIENT INTRODUCTION

Name: _____ **Date:** _____

Preferred Name: _____ **Email:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Mobile #:** _____

Gender: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Other

Date of Birth: _____ **Social Security #:** _____

Referred By: ☐ *Family OR Friend:* _____ ☐ *Insurance* ☐ *Doctor* ☐ *Internet* ☐ *Other Source*

EMERGENCY CONTACT INFORMATION:

Name: _____ **Home:** _____ **Mobile:** _____

Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

Primary Care Physician: _____ **Doctor's Phone:** _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other:_____

PRIOR MEDICAL HISTORY: Please check all of the following that apply to you.

- ☐ Stroke *Date:*_____
- ☐ Dizziness / Fainting
- ☐ Numbness in Groin / Buttocks
- ☐ Epilepsy / Seizures
- ☐ Visual Disturbances
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Corticosteroid Use (Cortisone, prednisone, etc.)
- ☐ Osteoporosis
- ☐ Recent Fall *Date:*_____
- ☐ Recent Fever
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain at Night
- ☐ Cancer / Tumor (explain)_____
- ☐ **Medications:**_____
- ☐ **Surgeries:**_____
- ☐ **Other Health Problems (explain)**_____

PLEASE FEEL FREE TO USE REVERSE SIDE OF PAPER – Copies of Medications/Surgeries Welcome

FAMILY HISTORY

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Problems/ Stroke
- ☐ Rheumatoid Arthritis

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED

History of Current Condition

NAME:_____ **DATE:**_____

Are you currently pregnant? Yes / No If Yes, How far along: _____

Is this a flare up of a previous condition?: Yes / No

PLEASE LIST ALL AREAS OF CONCERN YOU WOULD LIKE ADDRESSED:

_____

When did your condition/flare up start?: _____ What caused it: _____

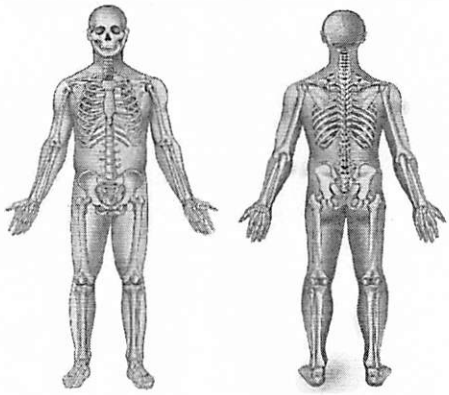
Does the pain radiate to additional area of your body? Yes / No If Yes Where:_____

Have there been any new traumas? (auto accidents, falls, etc.) Date of Injury: _____/_____/_____

New or Recent surgeries? Yes / No If yes, what surgery and when?:_____

Is the discomfort:: Aching / Dull / Burning / Sharp / Stabbing / Stiff / Numb-tingling / Other: _____

Mark areas of complaint



Please Circle Pain Intensity

1-2: Mild Pain

2-4: Mild - Moderate Pain

4-6: Moderate Pain

6-8: Moderate - Severe Pain

8-9: Severe Pain

Is your complaint getting : Better / Same / Worse **from when it started most recently?**

How often do you feel the discomfort? 16+ hours / 10-16 hours / 7-10 hours / 3-7 hours / 1-3 hours

What makes it feel better: Ice / Heat / Rest / Massage / Stretching / OTC or RX meds / Chiropractic / Other:

_____

Have you seen another provider for this complaint: No One / Chiro / MD / PT / Massage / ER / Other

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ Where & When _____

What aggravates your pain? (please select any that apply)

	Immediately	5 min.	10 min.	Other
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Drive Car	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Lie Down	☐	☐	☐	☐

	Immediately	5 min.	10 min.	Other
Sit	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Reach overhead	☐	☐	☐	☐
Use computer	☐	☐	☐	☐
_____ *(other)*	☐	☐	☐	☐

Patient Signature: _____ **Date of birth:** _____

SURPRISE CHIROPRACTIC

Louis V. Verloop, D.C

14515 W Grand Ave suite #C128, Surprise, AZ 85374

P : 623-544-9111 F : 623-544-9333 E: Surprisechiropractic@gmail.com

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and that the fees for the professional services rendered to me will be immediately due and payable.

ASSIGNMENT OF BENEFITS

I hereby authorize Surprise Chiropractic, LLC to release any information necessary to process this claim and assign ALL BENEFITS payable directly to Surprise Chiropractic, LLC. I waive the Statute of Limitations regarding my chiropractic physician's right to recover. I understand that whatever amount is not collected from insurance proceeds, (whether it be all or part, when insurance benefits exhaust or are denied for whatever reason), I am personally responsible. If collection or legal action should become necessary in payment of services rendered by Surprise Chiropractic, LLC, I understand that I will be personally responsible for all fees incurred by Surprise Chiropractic, LLC, made to collect that payment due.

CONSENT TO RELEASE OF INFORMATION

I hereby authorize and release the chiropractic physician and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information (PHI). The Notice of Patient Privacy Practices describes the uses and disclosures of my PHI that will occur in payment of my bills and coordination of care within our office, as well as, management of health care and related services within Surprise Chiropractic. The Notice of Privacy Practices describes my rights and the duties of Surprise Chiropractic with respect of my PHI. Upon request the Notice of Privacy Practices will be provided at the front desk. Surprise Chiropractic reserves the right to change privacy practices. I may retain a revised copy at any time upon request.

By initialing the above and signing this document, I acknowledge and understand my rights as a patient.

Printed Name: _____ **DOB:**_____

Patient Signature: _____ **DATE:**_____

AUTHORIZATION (HIPAA RELEASE)

I _____, give authorization to the following individuals listed below to:

- Communicate with Surprise Chiropractic by way of text, emails, in person, or phone on my behalf to discuss my schedule, reschedule, or cancel appointments. **( ) YES ( ) NO**
- Communicate in regard to billing and results pertaining to my care with Surprise Chiropractic. **( ) YES ( ) NO**

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name: _____Relationship: _____

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INFORMED CONSENT TO CHIROPRACTIC, SOFTWAVE, & DECOMPRESSION TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and decompression procedures including various modes of therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services will be performed by a Physician of Chiropractic named here Dr. Louis V. Verloop now or in the future at this office. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with clinic personnel. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractic physician to exercise judgment during the course of the procedure which the chiropractic physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the *Patient*:

_____ _____

Print Name of Patient *Signature of Patient*

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

_____

Print Name of Patient

_____ _____

Print Name of Representative *Signature of Representative*

Form to be maintained in the patient's health record.

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PHOTO/VIDEO RELEASE FORM:

I, _____, hereby grant Surprise Chiropractic and its representatives the irrevocable and unrestricted right to use and publish photographs and/or videos of me, taken by Surprise Chiropractic or its agents, for the purpose of patient education, marketing, advertising, or any other lawful purpose.

I authorize Surprise Chiropractic to copyright, use, and publish the same in print and/or electronically. I agree that Surprise Chiropractic may use such photographs and/or videos of me with or without my name and for any lawful purpose, including but not limited to, publicity, advertising, marketing, and web content.

I waive any right to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection therewith or the use to which it may be applied. I release, discharge, and agree to hold harmless Surprise Chiropractic and its representatives from any and all liability that may arise from the use of the photographs and/or videos.

I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents of this document. This release shall be binding upon me and my heirs, legal representatives, and assigns.

Patient Signature: _____ Date:_____

Please check below if you do not wish to participate:

☐ I do not wish to have my information released INITIALS: _____

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ **Today's Date:** _____

ACCIDENT INFORMATION

WHERE were you sitting in the vehicle?

☐ *Front seat – **Driver OR Passenger*** ☐ *Rear Seat– **Behind Driver*** ☐ *Middle* ☐ *Behind Passenger* ☐ *2nd Row* ☐ *3rd Row*

Were you using a seatbelt? ☐ *Yes* ☐ *No* **Did the airbags deploy?** ☐ *Yes* ☐ *No*

Did you receive an injury to the head? ☐ *Yes* ☐ *No* **Lose unconscious?** ☐ *No* ☐ *Yes (How long?)* _____

AT THE TIME OF THE ACCIDENT

***Where* were symptoms felt AT THE TIME of the accident?** ☐ *Neck* ☐ *Upper back* ☐ *Lower back* ☐ *Other (Please Explain Below):*

_____

Describe the discomfort AT THE TIME of the accident. ☐ *Aching* ☐ *Burning* ☐ *Dull* ☐ *Sharp* ☐ *Stiff* ☐ *Tingling*

Additional symptoms at the time of the accident? ☐*Anxiety* ☐ *Exhaustion* ☐ *Stunned* ☐ *Other: (Please Explain Below)*

_____

Did you receive treatment? ☐ ***Primary Care*** ☐ ***Hospital/Urgent care*** ☐ ***Self Treated @ Home with:*** ☐ *rest* ☐ *heat* ☐ *ice*

What type of treatment was received after collision? _____

Where did you receive treatment? _____

SINCE THE ACCIDENT

Are your symptoms? ☐ *Improving* ☐ *Getting Worse* ☐ *Same*

Are your work activities restricted because of this accident/injury? ☐ *Yes* ☐ *No*

(How?) _____

Have you missed any work since this accident? ☐ *No* ☐ *Yes (Dates?)* _____

Additional Notes:

AUTOMOBILE ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____ **Today's Date:** _____

Name of Driver, ***if not self:*** _____ **DOB**_____

Vehicle Year_____ **Vehicle Make**_____ **Vehicle Model**_____

Name of Driver of the *OTHER* vehicle: _____

Vehicle Year_____ **Vehicle Make**_____ **Vehicle Model**_____

Date of Accident: _____/_____/_____ **Time** _____: _____**AM/PM**

AUTO INSURANCE INFORMATION

***Your* Auto Ins:** _____ **Policy #:** _____

Claim #: _____ **Phone #:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

***Other's* Auto Ins:** _____ **Policy #:** _____

Claim #: _____ **Phone #:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Have you retained an Attorney? ☐ *Yes* ☐ *No*

Name: _____ **Phone:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

ACCIDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS)

Location of Accident: _____

Briefly Explain what happened: _____

_____

_____

_____

_____

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Authorization and Assignment of Benefits

You, Surprise Chiropractic are authorized to release any information that you, Surprise Chiropractic, deem appropriate concerning my physical condition for reimbursement of charges incurred. In that this office is waiting for payment of some of its fee, I agree to provide Surprise Chiropractic with information and forms regarding any potential source of fee payment to assist in any way I can, and I hereby assign to Surprise Chiropractic my rights to receive payment from negligent parties and from insurance companies. Payment should be payable to and mailed to Surprise Chiropractic at the above address. If my policy prohibits assignment, then checks should be made jointly to me and Surprise Chiropractic and mailed to the above address. I authorize the direct payment to you (Surprise Chiropractic) of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to me or you based in whole or in part upon the charges made for services.

I understand that if Surprise Chiropractic receives more than their fees, Surprise Chiropractic will pay the credited amount to me, the patient.

I permit Surprise Chiropractic to endorse co-issued remittance for the convenience of credit to my account.

In the event any insurance company, obligated by contractual agreement, to make payment to me or towards your services refuse to make such payment upon demand, I hereby assign and transfer to you, Surprise Chiropractic the cause of action that exits in my favor against any such companies, the names of which is believed to correctly set forth under pertinent data and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort had been made to collect the sums due from any insurance company or companies contractually obligated, you Surprise Chiropractic will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the state of AZ.

I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full. This authorization for assignment will be in continual effect until revoked by both parties.

This document shall not be superseded by any other document sent to you, if any, by my attorney pertaining to disbursement of funds for my medical bills.

A photocopy of this form shall be valid as the original.

In the event of default, I agree to pay for collections and/or attorney fees.

Notice of Medical County Lien **(For patients who have an auto accident or other personal injury claim) In order to ensure that the parties liable for payment of your claim are fully aware of the fact that Surprise Chiropractic is extending credit to you for your care in our office, we will be filing a medical county lien. This lien will be released once payment has been paid by all responsible parties.**

Signature of Patient _____ **Date** _____

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Attorney Authorization/Lien

Attorney Name:_____

Patient Name:_____

Address:_____

Date of Birth:_____

I do hereby authorize Surprise Chiropractic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, complete billing and any other pertinent information regarding my care as a result of the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor's office such sums as may be due and owing them for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, medical insurance payment, judgment or verdict, as may be necessary to adequately protect said doctor's office. I hereby further give a lien on my case said doctor's office against any and all proceeds of my settlement, medical insurance payment, judgment or verdicts which may be paid to you, my attorney, or to myself as a result of the injuries for which I have been treated or injuries connected therewith.

I understand that I am directly and fully responsible to said doctor's office for all medical bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection, and in consideration of his awaiting payment, judgment or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the items of the above and agrees to withhold such sums for any settlement, medical insurance payment, judgment or verdict as may be necessary to adequately protect said doctor's office named above.

Attorney Signature: _____ Date: _____

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Authorization Request to Release Health Information

Date: _____

Patient Name: _____

DOB: _____

I hereby grant permission and authorize the following medical provider and/or organization to disclose the following information:

Medical History	
Medical Records	
Diagnosis	
Reports	
Treatment	
X-Rays	
X-Ray Report	

Concerning my:

Illness	
Accident	
Injury	
Other:	

Please email any imaging to surprisechiropractic@gmail.com or mail CD's to our address

The following medical providers, and/or organizations are authorized to make the disclosure from:

Doctor/Organization: _____

Address: _____

Phone: _____ Fax: _____

To be released to: **Surprise Chiropractic**
14515 W Grand Ave Suite 128, Surprise, AZ 85374
PH: (623)544-9111 / FX: (623)544-9333

For the purpose of: _____

I understand that I have a right to receive a copy of this authorization upon my request.

Signed: _____ Date: _____

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WAIVER OF HEALTH INSURANCE BENEFITS

Name: _____ *Date of Injury*: _____

I, _____, do hereby acknowledge that I have Health Insurance and that I have certain rights and protections granted to me pursuant to ARS 33-931 relating to medical liens. Due to my provider agreeing to await payment for services rendered, resulting from my Motor Vehicle Accident occurring on _____, I elect to not use any of my Health Insurance benefits that may be available to me. This waiver of benefits applies only to the aforementioned accident and not to any other services that may be provided once my case has been resolved. I acknowledge that I am personally responsible for all services and amounts payable to Surprise Chiropractic, should Surprise Chiropractic not be reimbursed through my settlement proceeds, award or other payments received by me for my accident. I specifically give permission to Surprise Chiropractic to file a medical lien, pursuant to ARS 33-931 to protect their right to be paid for services rendered.

To be completed by the *Patient*:

_____ _____

Print Name of Patient *Signature of Patient*

_____

Today's Date

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

_____

Print Name of Patient

_____ _____

Print Name of Representative *Signature of Representative*