Vitality Chiropractic, P.C.

857 Health Park Blvd.
Grand Blanc, MI 48439

Welcome

Patient Information

Date_____ Sex: □ M □ F Age: _____
Patient_____
Address_____
_____
City State Zip Code

Birth Date_____ Height_____Weight _____

□Single □Married □Widowed □Separated □Divorced

Patient SS#_____
Occupation_____
Employer_____
Employer Address_____
Employer Phone #_____

Spouse's Name_____
Birth date_____ SS#_____
Occupation_____
Spouse's Employer_____
Whom may we thank for referring you?_____
_____

Insurance

Who is responsible for this account?_____
Relationship to Patient_____

Insurance Co_____
Group #_____

Is patient covered by additional insurance? □ Y □ N

Subscriber's Name_____
Birth Date _____SS#_____
Relationship to Patient_____
Insurance Co._____
Group #_____

_____
Responsible Party Signature

_____
Relationship Date

Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you:_____
_____

IN CASE OF EMERGENCY, CONTACT:
Name_____Relationship_____
Home Phone_____
Work Phone_____Ext_____
Email:_____

Accident Information

Is condition due to an accident? □ Y □ N Date _____
Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp □ Other
Attorney Name/Phone # (if applicable)_____
_____

Health History

What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None
□ Other _____

Name and address of other doctor(s) who have treated you for your current problem:_____

Date of Last: Physical Exam_____ Spinal X-Ray _____Blood Test_____
Spinal Exam_____ Chest X-Ray _____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Who is your primary care physician (First/Last Name)?_____

What is their address?_____
How long has he/she been your primary doctor?_____
When was your last appointment with your primary doctor? _____
Was your last visit with your primary doctor related to your current problem? Yes No
Do you mind us contacting your primary doctor regarding your condition? Yes No

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV □ Y □ N
Alcoholism □ Y □ N
Allergy shots □ Y □ N
Anemia □ Y □ N
Anorexia □ Y □ N
Appendicitis □ Y □ N
Arthritis □ Y □ N
Asthma □ Y □ N
Bleeding Disorders □ Y □ N
Breast Lump □ Y □ N
Bronchitis □ Y □ N
Bulimia □ Y □ N
Cancer □ Y □ N
Cataracts □ Y □ N
Chemical Dependency □ Y □ N
Chicken Pox □ Y □ N
Diabetes □ Y □ N
Emphysema □ Y □ N

Epilepsy □ Y □ N
Fractures □ Y □ N
Glaucoma □ Y □ N
Goiter □ Y □ N
Heart Disease □ Y □ N
Hepatitis □ Y □ N
Hernia □ Y □ N
Herniated Disc □ Y □ N
Herpes □ Y □ N
High Cholesterol □ Y □ N
Kidney Disease □ Y □ N
Liver Disease □ Y □ N
Measles □ Y □ N
Migraine Headaches □ Y □ N
Miscarriage □ Y □ N
Mononucleosis □ Y □ N

Multiple Sclerosis □ Y □ N
Mumps □ Y □ N
Osteoporosis □ Y □ N
Pacemaker □ Y □ N
Parkinson's Disease □ Y □ N
Pinched Nerve □ Y □ N
Pneumonia □ Y □ N
Polio □ Y □ N
Prostate Problem □ Y □ N
Prosthesis □ Y □ N
Psychiatric Care □ Y □ N
Rheumatoid Arthritis □ Y □ N
Rheumatic Fever □ Y □ N
Scarlet Fever □ Y □ N
Stroke □ Y □ N
Suicide Attempt □ Y □ N

Thyroid Problems □ Y □ N
Tonsillitis □ Y □ N
TIA □ Y □ N
Tuberculosis □ Y □ N
Tumors Growths □ Y □ N
Typhoid Fever □ Y □ N
Ulcers □ Y □ N
Vaginal Infections □ Y □ N
Venereal Disease □ Y □ N
Whooping Cough □ Y □ N
Other_____
_____
_____
_____
_____

Exercise	Work Activity	Habits	
□ Never	□ Sitting _____ hrs/day	□ Tobacco	Packs/Day_____
□ Occasionally	□ Standing___ hrs/day	□ Alcohol	Drinks/Week_____
□ Frequently	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day_____
□ Regularly	□ Heavy Labor	□ High Stress Level	Reason_____

Are you Pregnant? □ Yes □ No Date of last menstrual period_____ Due date_____
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time. _____
initial

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		

Surgeries _____ _____

Car Accidents _____

Medications/Uses	Allergies	Vitamins/Herbs/Minerals

Family History

If there is a family history of any of the following health conditions, please check the appropriate box corresponding to your maternal (mother's) or paternal (father's) side.

	Mother	Father		Mother	Father
Respiratory Disease	□	□	Cancer	□	□
Hypertension	□	□	Heart Disease	□	□
Gastro-Intestinal Disease	□	□	Osteoporosis	□	□
Diabetes	□	□	Thyroid Disease	□	□
Skin Disease	□	□	Degenerative Disc Disease	□	□
Neurological Disease	□	□	Stroke	□	□
Arthritic Disease	□	□	Genital-Urinary Disease	□	□

Welcome to our multi-specialty group providing chiropractic care, family practice, spinal decompression, and cold laser therapy.

Our office & staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity & concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. The Health Care Privacy Notice will explain when, where & why your confidential health information may be used, stored and/or shared & is part of this document which is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

We are available to immediately see new patients the same day or through our 24 hour- 7 day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & I believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of medicine, chiropractic, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore, I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of this Facility.

Initial: _____

HEALTH CARE PRIVACY NOTICE (HIPPA)

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff & patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to Vitality Chiropractic.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal & state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is

available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information as (PHI). PHI is information about you, including demographic information, that may identify you & that may relate to your present, future & past physical or mental health or condition & the care & treatment you receive from our practice. This Notice describes how medical information about you may be used & disclosed & how you can obtain access to this information. Please read this Notice & ask questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care & treatment; paying your health care bills; and to support the operations of this practice. Your doctor & staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review & receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State Law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed, and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint from the Compliance Officer and/or the Office of Civil Rights. All complaints must be filed within 180 days of when you know or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility. Should anyone call this Facility asking for you, you authorize this Facility to release the following:

- □ any patient information
- □ appointment information only

Name: _____ Patient/Guardian Signature: _____

INSURANCE RELEASE FOR INFORMATION AND AUTHORIZED REPRESENTATION ON THE PATIENT'S BEHALF

In consideration of your undertaking to render care, I agree to the following:

Release of Information: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me at Vitality Chiropractic ("the facility").

Right to Receive Payment: I authorize and assign "the facility" and/or its representatives, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sum. I further authorize the endorsement of my name to any draft or check containing my name which you are legally entitled.

Assignment of Right to Sue: In the event any insurance company or attorney, obligated by contractual agreement to issue payment to me for your service charges, refuses to pay upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand whatever amounts you do not collect from said insurance proceeds shall be paid by me (the patient). I also assign "the facility" and grant the right of lien against all claims against any 3rd party whose negligence may have caused my injury up to the amount of the bill for treatment. I waive the Stature of Limitations regarding "the facility's" right to recover from me directly. I hereby direct my attorney to cooperate, assist and not interfere with "the facility" in recovering any Med-Pay benefits I may be entitled to.

I designate **Dr. Andrea Towers of Vitality Chiropractic, P.C.** (hereafter referred to as "my doctor"), to the full extent permissible under the Employee Retirement income Security Act of 1974 (ERISA) and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named "doctor". These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any applicable remedies, all in connection with medical or other health care expense(s) as the result of services I received from "my doctor".

I hereby appoint "my doctor" located **at 857 Health Park Blvd, Grand Blanc MI** to have full power and authority to act on my behalf as my **AGENT** and perform any acts necessary regarding: securing all information, rights and benefits guaranteed to me under federal (ERISA) and state law according to current Summary Plan Document(s) of my health insurance policy/plan:

In the above matter only, my **AGENT** has full authority to secure, prepare, sign with any governmental body including, but not limited to, those governing ERISA, Department of Labor and all agencies with oversight/authority in federal and state insurance enforcement actions. In the above matter only, my **AGENT** may also institute, supervise, prosecute, defend, intervene in, abandon, compromise, arbitrate, settle,

dismiss and appeal from any and all legal, equitable, judicial, or administrative hearings, actions, suits, proceedings, attachments, distress or arrests on my behalf.

I fully understand, comprehend and agree to the term of the Irrevocable Assignment of Benefits/Power of Attorney and Designation of Authorized Representative and choose to make effective on the date signed.

_____	_____	_____
(Patient Printed Name)	(Patient Signature)	(Date)

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. **Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. **Health:** The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. **Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care and/or physical therapy treatment on this basis.

Initial: _____

CONSENT TO TREAT A MINOR

Consent to evaluate and adjust a minor child: I, _____ being the parent or legal guardian of _____and have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care and/or physical therapy treatment.

_____	_____	_____
(Patient Printed Name)	(Patient Signature)	(Date)

INSURANCE POLICIES- PAYMENT TERMS & CONDITIONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us, therefore it is your responsibility to know what your insurance benefits are per your policy. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.
2. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.
3. Co-pays, deductibles & all non-covered service charges are due the day the service is rendered.
4. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
5. Patient agrees to allow the facility to use any past form of payment on file to bring their account up to date for services rendered, as well as, agrees to release and authorize this facility to sign any form of payment presented to the facility not signed for services rendered.
6. All account balances, including automobile & work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office & such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee & it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is

fully responsible for all money owed this Facility for any & all treatment, products & services rendered to the patient and/or minor.

7. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements or massage therapy.

8. This Facility reserves the right to charge an additional service fee computed by a 'periodic rate' of 2% per month- 24% per annum to all balances owed 30+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30 charge.

9. Should you agree to provide any testimonials (video, written, verbal, emailed, etc…), you agree and release the right to use these in any marketing or advertising for the Facility.

10. If your insurance carrier sends you payment for services rendered by the Facility, you agree to send or bring the full payment to our office immediately upon receipt.

11. All special order and custom-made supplies/supports/products are non-refundable.

12. Michigan state law dictates that all patient records, including x-rays, be kept on file for a minimum of 7 years. For an additional fee (state mandated rates for paper plus any associated courier fees and radiographic copy charges), copies will be made available upon patient request. Processing time is one (1) week.

Initial: _____

PATIENT CONSENT & SIGNATURE

By my signature and/or initials above and below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Informed Consent, Health Care Privacy Notice, Facility Terms & Conditions, Insurance Policies, Consent to Treat a Minor, Terms of Acceptance, Irrevocable Assignment of Benefits/Power of Attorney and Designation of Representation, and fully understand and have had all of my questions answered to my satisfaction. Date of acknowledgment for all stated sections is reflected in the "Patient Consent & Signature" section. A photocopy of this document shall be considered as effective and valid as an original.

_____	_____
Print Name of Patient	Witness
_____	_____
Signature (if minor, parent must sign)	Date