

Patient Name: _____ **Date:** _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Email Address: _____

For appointment confirmation (choose one) ___ phone call (circle: home or cell) ___ text ___ email ___ no reminder

Social Security # _____ or Driver's License#/state _____

Employer _____ Occupation _____

Spouse's name: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

ACCOUNT INFORMATION

Person ultimately responsible for this account

Name: _____ Relationship to patient: _____

Address: _____ (students: if appropriate put parents address here)

City: _____ State: _____ Zip: _____

Phone: _____ Driver's License #: _____ State: _____

EMERGENCY INFORMATION

Contact/Relationship: _____ Phone: _____

INSURANCE INFORMATION

Insurance Co.: _____ Subscriber's name: _____ Birth Date: _____

Relationship to patient: _____ Additional insurance: ___Y ___N Insurance Co.: _____

ACCIDENT INFORMATION

Is today's issue related to? ___ Auto accident ___ Worker's Comp ___ Neither If yes, date of injury: _____

Insurance name: _____ Claim#: _____ Phone _____

Attorney (if applicable): _____ Phone _____

Patient Name: _____

Date: _____

BILLING CONSENT

This office will bill your insurance company as a courtesy. You are ultimately responsible for all charges associated with your account. If you choose not to bill your insurance and accept a time of service discount, you will waive any in network adjustments by Northwest Health & Healing Center and the courtesy of us billing insurance

for you. If you do not take care of your balance within a reasonable amount of time, the providers may exercise their right to send your account to a collection agency.

This office will contact your insurance company to try to determine your benefits. You also need to contact the insurance company to confirm your benefits. We will communicate to you what benefits we were quoted. There is no guarantee that what the insurance pays will match the quoted benefit. There may be a balance still owed, even after you have paid your co-payment or co-insurance.

Massage Fees

There are two types of massage service available at Northwest Health and Healing Center. They are distinctly different services and have different fees.

1. Wellness Massage. Scheduled directly with one of the licensed massage therapists, you and the therapist choose the amount of time you want, what type of massage you receive, and what areas of the body are massaged. The therapist is paid directly the fees that they have determined for their services. This is their independent operation and you are their client, not a patient. Although your doctor may recommend you "get a massage," the wellness massage is not typically reimbursed by insurance and is not based on diagnosis codes or any coding system.

2. Prescribed Massage. Your doctor prescribes massage therapy as a part of your care. The massage therapist is now acting as a Certified Chiropractic Assistant, following the exact instructions of the doctor for the type of massage, length of massage, and the areas treated. The massage is based on diagnosis and treatment codes established by the medical insurance industry, and the doctor must justify medical necessity. The therapist is hired and paid by the doctor, not you. You and/or your insurance company are billed by the doctor, not the massage therapist, for each 15 minute unit of massage. The code and rate is the same as if the doctor had done the massage themselves. Prescribed massage is a more complex service and at a higher cost, depending on the length of massage.

Note: Because of state regulations, a prescribed massage must be in a supervised situation by the prescribing doctor, hence only usable in this facility and for the period indicated on the prescription.

Please note our cancellation policy:

With 24 hours notice, there is no charge to change or cancel your appointment. If you cancel within the 24 hour time period, or neglect to come to your appointment, it may result in a fee. The advanced notice of your appointment change allows other patients to be scheduled in your cancelled time slot.

I have read and agree to the Billing Consent. Signature _____ **Date** _____

Patient Name: _____

Date: _____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose(s) for the release:

Many patients visit more than one healthcare provider in this office; therefore, this release would allow all providers involved in your care to have access to your protected health information in this office. The purpose of the release is to inform you that one or more of the providers listed below may inadvertently see some of your demographic information or some/all of your protected health information during normal office activities.

I understand that:

- Treatment will be conditional on whether I sign this Authorization.
- This authorization does not have expiration.

I authorize Dr. Sorah, Dr. House, Dr. Winckler and Ondria Holub to use and/or disclose both:

- *Protected Health Information (PHI)*: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.
- *Sensitive Protected Health Information (SPHI)*: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

Signature _____

Authorization to communicate via email

This is to inform you that our office is not currently using an email server that complies with all HIPAA standards regarding privacy. We use Gmail and email servers from One & One (web hosting.) Although these companies make strong endeavors to protect data, they do not comply with the strictest HIPAA regulations. Therefore, our office must obtain your permission to communicate with you via email. It is our responsibility to inform you that there is some risk that other individuals may intercept these email communications sent to you, and they may contain private health information. By signing below, you are giving us permission to communicate with you in this way.

Signature: _____

Today's date: _____

I hereby authorize Michael Sorah DC, Rolland House DC, and/or John Winckler to provide chiropractic services for me. I have read the "patient informed consent" and agree to it. (located on the intake paperwork clipboard)

Signature: _____ Print Name _____

Patient Name: _____

Date: _____

HIPAA 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 of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative
Printed name: _____

Date

Patient Name: _____ **Date:** _____

1. Reasons for seeking chiropractic care:

Primary reason:

Secondary reason:

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
 Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
 Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
 None of the above

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies: _____

D. Medications:

Medication

Reason for taking

| Medication | Reason for taking |
|------------|-------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

E. Surgeries:

Date

Type of Surgery

| Date | Type of Surgery |
|-------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Patient Name: _____

Date: _____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery

Outcome

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

G. X-ray, MRI, CT scan or other diagnostic tests

Date

Results

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Deaths in immediate family: _____

Cause of parents or sibling's death

Age at death

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

Review of Systems

Patient Name: _____

Date: _____

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell
 Strokes/TIAs Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes
 Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections
 Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation
 Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools
 Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive
 Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
 Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use
 Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery
 Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia
 Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **[Dr. Sorah, Dr. House, and/or Dr. Okerstrom]** for services performed.

Patient or Guardian Signature _____

Date _____

NEW PATIENT HISTORY FORM

Patient Name: _____

Date: _____

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

Patient Name: _____

Date: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 5 _____

Patient Name: _____

Date: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day