PATIENT CASE INFORMATION

Date: _____ **Patient No:** _____

Patient Information

Name: *(First MI Last)* _____ **Preferred Name:** _____

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

Cell Phone: _____ **Cell Carrier:** _____ **Home Phone:** _____

Email Address: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

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

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

** **Referred By:** _____ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: _____ **Relationship:** _____

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

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

***** *(Please supply insurance cards to office staff so that they can be copied)*

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing, and/or therapeutic services on the above, in accordance with this state's statutes. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____ ***Signature of Parent or Guardian:*** _____ ***Date:*** _____

(It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged)

COMPLAINT INFORMATION

Date: _____ **Patient No:** _____

History of Current Condition

Major Complaint: _____

Secondary Complaint: _____

When and How this began? _____

_____

_____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _____

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected? (*Describe*) _____

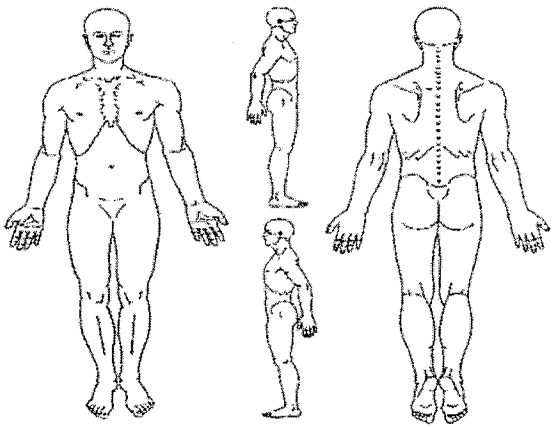
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _____ Where: _____

Other Diagnostic Testing? X-rays / MRI / CT / Other: _____ Where: _____

Pain/Complaint Diagram

SYMPTOM DIAGRAM



P___ Pain T ___ Tender

N ___ Numb H ___ Hypoesthesia

S ___ Spasm

Patient Signature: _____ ***Physician's Initials:*** _____

REVIEW OF SYSTEMS

Patient Name: (First MI Last) _____ **Patient No:** _____

Review of Systems

General:
- ☐ Weight Change
- ☐ Fatigue
- ☐ None

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Other: _____
- ☐ None

Neurological:
- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Dizziness
- ☐ Headaches
- ☐ Other: _____
- ☐ None

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Loss of Memory
- ☐ Other: _____
- ☐ None

Genitourinary:
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Bed Wetting
- ☐ Other: _____
- ☐ None

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Change of Bowel
- ☐ Painful Bowel
- ☐ Nausea Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ None

Heart:
- ☐ Rapid Heartbeat
- ☐ Blood Pressure Prob.
- ☐ Swelling hands/ankles
- ☐ Other: _____
- ☐ None

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Lung Problems
- ☐ Other: _____
- ☐ None

Eyes and Vision:
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Other: _____
- ☐ None

Ears, Nose & Throat:
- ☐ Swollen glands in neck
- ☐ Ringing in ears
- ☐ Ear Ache
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ None

Endocrine & Lymphatic:
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cold Extremities
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Other: _____
- ☐ None

Women:
- ☐ Infertility
- ☐ Irregular periods
- ☐ None

Health History

Medications and Supplements:

Allergies to Medications: ☐ NONE

Name	Reaction

Current Medications & Supplements: ☐ NONE

Name	Dosage

Past Health History:

Surgeries: ☐ **NONE**

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐ **NONE**

Date	Describe

Family Health History: ☐ **NONE**

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐ Every Day ☐ Some Days ☐ Former ☐ Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Chiropractic Wellness Center

Lance A. Hoose D.C.

ASSIGNMENT OF BENEFITS FOR INSURANCE PURPOSES

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a daily basis as courtesy to you. You will be responsible for your deductible and/or Co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your Insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

I, _____ (print) acknowledge, except and agree that I am responsible for my deductible and/or Co-payment if not covered by my insurance company.

Signature:_____Date:_____

Assignment and Conveyance of Lien Interest for Personal Injury Patients

I hereby execute and provide an irrevocable Lien Interest and Assignment of proceeds to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/Medical payment insurance, policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), Claim(s) judgments, or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to Dr. Hoose/Chiropractic wellness Center by the insurance carrier out of those settlement proceeds to which I am entitled or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to Dr Hoose/Chiropractic Wellness Center. In the event my insurance settlement proceeds are paid directly to my attorney and I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to Dr. Hoose/Chiropractic Wellness Center and remit payment for all such sums upon receipt of my settlement award(s)

Patient Signature: _____ Date:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Chiropractic Wellness Center PLLC

2442 E 21st St Tulsa OK 74114

Lance A Hoose DC

Temperature:_____

BP:_____/_____ Pulse: _____bpm

Office Use Only

Coronavirus (COVID-19) Screening Questionnaire

Patient Name:_____ Date:_____

DOB: _____ Age:_____

1. Have you traveled anywhere in the last 3 weeks (especially outside the USA)? ☐ No ☐ Yes If yes where?

   _____

2. Have you been in contact with anybody that was sick in the last 3 weeks? ☐ No ☐ Yes If so please give specifics. (This could be a friend, family or co-worker.)

   _____

   _____

3. Have you been to a region of high contagion? ☐ No ☐ Yes If yes where?

   _____

4. Do you have any symptoms of a cold or flu? ☐ No ☐ Yes
5. Do you have a cough? ☐ No ☐ Yes
6. Do you have any difficulty breathing? ☐ No ☐ Yes
7. Do you have a runny nose? ☐ No ☐ Yes
8. Do you have a sore throat? ☐ No ☐ Yes
9. Do you have any illness related body aches? ☐ No ☐ Yes
10. Have you Previously Tested for COVID-19? ☐ No ☐ Yes
    a. Positive for IgM ☐ No ☐ Yes
    b. Positive for IgG ☐ No ☐ Yes

I attest that I have fully and properly answered the above questions and the information is complete.

Patient's / Guardian's Signature _____ **Date:**_____