living pure chiropractic

Patient Name: _____ **Date of Birth:** ___/___/_____

NEW PATIENT REGISTRATION AND AUTO ACCIDENT QUESTIONNAIRE

ADDRESS_____CITY_____ STATE _____ ZIP CODE _____

Phone (H) _____(W)_____ (C) _____

Which is best contact number? Circle: Home Bus. Cell May we leave message at these numbers? H B C

EMAIL ADDRESS: _____@_____

Sex: M F Marital Status: M S D W Age_____ Social Security #_____

Occupation_____
Employer_____

Referred by: _____

Please Provide Us With The Appropriate Insurance Information:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____Telephone: (_____) _____Insured: _____

Claim #: _____Policy #: _____

Claim Representative: _____ Telephone: (___)_____ Fax: (___) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____Policy #: _____Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

17235 N 75th Ave F-110 Glendale, AZ 85308
p 623-572-4476 f 623.566.4918 e info@lpchiropractic.com
www.livingpurechiropractic.com

Patient Name: _____ **Date of Birth:** ____/____/_____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Most Recent or Current Primary Care Provider: _____ Phone:_____

Most Recent or Current Specialists and Types: _____ Phone : _____
_____ Phone: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

DATE of auto injury: _____ HOUR of accident: _____AM/PM

Did you lose consciousness? ☐ Yes ☐ No If Yes, for how long? _____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ *Loss of Smell*
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ *Loss of Taste*
☐ *Anxiety*	☐ *Sensitivity to Light*	☐ *Jaw Pain (TMJ)*	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

1. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   - A. Loss of Range of Motion: yes/no
     - a. What body parts: _____
   - B. Visual Disturbance :yes/no ☐ blurring L/R ☐ floaters L/R ☐ vision loss L/R ☐ hypersensitivity L/R
     % of time: ___ % of time: ____ % of time: ____ % of time: ___
   - C. Dizziness: yes/no % of time: ____
   - D. Anxiety: yes/no % of time: ____
   - E. Depression: yes/no % of time: ____
   - F. Difficulty Sleeping: yes/no

☐ Other Symptoms:

_____

Have you lost time from work or school? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Patient Name: _____ **Date of Birth:** ____/____/_____

2. **REASONS for seeking care due to this accident (list most to least severe):** #1. _____

#2 _____ #3 _____ #4_____

#5 _____ #6 _____ #7 _____

Were there any symptoms which you had after the crash/accident that have now resolved? (please list):

_____

3. **Previous interventions, treatments, medications, surgery, or care you've sought for these complaint(s) prior to coming to our office:**

_____

_____

Have you done any of the following since the crash/accident?

☐ Ice ☐ Medication (name) _____ ☐ Rest
☐ Heat (any kind) ☐ Exercise ☐ Other_____

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____

Treatment Given at any of these facilities? _____
Any imaging or special tests performed at these facilities? _____

_____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

_____

4. **PAST and CURRENT 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 (sports, auto injury, slip and fall): (Please include dates)**

_____

Patient Name: _____ **Date of Birth:** ____/____/_____

Have you ever broken any bones? Which?

_____

C. **Allergies to medications or other:**

_____

D. **Medications: (attach separate list if necessary)**

Medication Reason for taking/How Long?

_____

_____

_____

_____

E. **Surgeries:**

Type of Surgery Date

_____

_____

_____

_____

F. **Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery Outcome

_____

_____

_____

_____

5. **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 siblings death **Age at death**

_____

_____

_____

Patient Name: _____ **Date of Birth:** ____/____/_____

SOCIAL AND OCCUPATIONAL HISTORY:

A. **Job description:**

_____

B. **Work schedule:**

_____

C. **Exercise and Frequency:**

_____

D. Major Stressors in your life? _____

E. Diet: Eating Habits: Skip Breakfast? ___ Circle: #Meals per day: 1 2 3 4 5 >5 Vegetarian Vegan

F. **Sleep:** # hours per night (average): _____ Position: (Circle): right side left side, back, front

Trouble Falling Asleep? _____ Staying Asleep? _____Do you awaken at night? _____ Time? _____

Age of Mattress: _____Pillow: _____ Type of Mattress: _____ Pillow: _____

How do your current conditions interfere with your:
Work or career? _____Household Responsibilities?_____

Recreational Activities? _____Personal Relationships? _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No: How much per day? _____ Do you drink alcohol? ☐ Yes ☐ No; How much per week and type?_____

REVIEW OF SYSTEMS

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

Patient Name: _____ **Date of Birth:** ____/____/_____

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 for us to know?

_____

NEW PATIENT HISTORY FORM

(Please start at top of your body and work your way down- head→ neck →shoulders 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? _____

Patient Name: _____ **Date of Birth:** ____/____/_____

SYMPTOM 1 (continued)

- 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 _____

- 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

Patient Name: _____ **Date of Birth:** ____/____/_____

SYMPTOM 3 (continued)

- 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

Patient Name: _____ **Date of Birth:** ____/____/_____

SYMPTOM 5 _____

- 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 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

Patient Name: _____ **Date of Birth:** ____/____/_____

SYMPTOM 7 _____

- 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

Please read these statements and initial your agreement to each:

Initials: ___ I acknowledge that any insurance I may have is an **agreement between me and the carrier** and that I am responsible for payment of any covered or non-covered services I receive.

Initials: ___ I grant permission to be called, texted or emailed to confirm or reschedule an appointment and to be sent cards, letters, emails or health information to me as an extension of care in the office.

Initials: ___ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Living Pure Chiropractic to provide me with chiropractic care and related services, in accordance with this state's statutes. I authorize payment of medical benefits to Living Pure Chiropractic, LLC for services performed.

Patient/ Guardian Sign: X _____ PRINT: _____ Date_____

Thank you for taking the time to complete this extensive history form. This helps us give you the best possible care specific to your needs!

Patient Name: _____ **Date of Birth:** ____/____/_____

OFFICE POLICY, ASSIGNMENT AND AGREEMENT
(Please read carefully and sign.)

Thank you for choosing Living Pure Chiropractic, LLC as your health care provider. A clear definition of our office policies will allow you, the patient and us, the doctors and clinic, to concentrate on the reason you are here-TO REGAIN AND MAINTAIN YOUR HEALTH.

Please read carefully SIGN AT BOTTOM OF PAGE TWO.

1. **NON-PARTICIPATING Provider Insurance**: *I hereby assign my rights and authorize and direct my insurance company, or other liable company, or any other concerned party to make payment directly to Living Pure Chiropractic, LLC. I am responsible for non-covered portion of billed services.* Insurance is designed to pay a percentage of your medical bills, up to the limit noted in your policy and not pay them completely. **By signing this policy you are appointing our office as attorney-in-fact to treat, negotiate and cash any settlement draft or check for any outstanding balances from the treatment provided. You also give Living Pure Chiropractic, LLC power of attorney to endorse checks made out to you to be credited to your account**. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Such services are ultimately your responsibility and will be due at time of service. In the event you receive any checks from your insurance company for services rendered to you by our providers, those payments are to be turned over to our office within 7 days of receipt. . **Note: for Personal Injury: We do not bill out of network services during a personal injury lien case UNLESS you have benefits available in reasonable number of visits. Doctors and staff determine this on case by case basis.**

2. **PARTICIPATING Provider Insurance:** As participating providers for certain plans, we are required to collect co-payments and deductibles up to the allowed amount determined by your insurance plan at the time of each treatment or service. Per our provider agreement it is considered fraud for us to collect from some patients and not from others. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Such services are ultimately your responsibility and will be due at time of service. In the event your insurance coverage changes to a plan where we are not participating as a provider, please refer to the previous paragraph. **Note: for Personal Injury: We do not bill in network services during a personal lien injury case.**

3. **SELF PAY Patients** (aka cash or non-insured): Self pay patients are asked to pay for all services on the same day those services are rendered. We accept Visa, Master Card, debit cards, cash or checks.

4. *I understand that I will be charged an interest fee in the amount of **2% monthly**, as provided by state law, when my account reaches 30 days past due. **If my account is not paid within 120 days** my account will be turned over to our contracted collection agency for further processing and I will be responsible for attorney fees, court costs and all accrued interest charges.* No additional appointments will be made for delinquent accounts until they are brought current.

6. *I understand that **a $35 service fee will be added for any checks returned** for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).*

6. **Limited Release of Medical Information**: *I authorize Living Pure Chiropractic, LLC to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these assignments.*

Patient Name: _____ **Date of Birth:** ____/____/_____

7. **Minor Patients**: The adults accompanying a minor, whether they are parents or guardians, are responsible for full payment regardless of custodial responsibility. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit, debit, cash or check before or at time of service.

8. *I understand and agree that health and accident policies are an arrangement between my insurance carrier and me.* ***I hereby authorize Living Pure Chiropractic LLC to furnish information to insurance carriers concerning my illness and treatments and hereby assign the doctors of Living Pure Chiropractic, LLC all payments for medical services*** *rendered to me or my dependents until revoked in writing. Any amount authorized to be paid directly to the office will be credited to my account upon receipt.*

9. *I understand that* ***if I suspend or terminate care****, any fees for professional services rendered to me will be immediately due and payable.*

10. **MISSED APPOINTMENT AND LATE CANCELLATIONS:** *I understand that if I am unable to make a scheduled appointment I need to contact Living Pure Chiropractic, LLC via phone 24 hours before that scheduled appointment.* Missed appointments slow your progress and prevent others in need of care from being seen. **A $25 fee** will be assessed for all missed appointments and those canceled with less than 24 hour advanced notice. This applies to chiropractic, massage and all therapies. We ask that you try to make up a missed appointment within 7 days of any cancellation.

11 Living Pure Chiropractic, LLC allows 60 days from the date of filing for the insurance company to process or pay a claim. They will submit medical insurance forms as a courtesy to their patients. *Arizona law allows insurance companies operating in its state no more than 30 days to process claims.* ***It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Living Pure Chiropractic, LLC if there is a change in my insurance coverage, residence or contact phone numbers.***

Ultimately, it is up to me to know my insurance benefits.

If you have any questions or concerns about the fees or services, please do not hesitate to speak with our staff. We strive to facilitate a comfortable, friendly environment where care is given on mutual terms. The undersigned certifies that he/she has read the foregoing and has received a copy if requested and is the patient or guardian to the patient to execute the above and accepted its terms.

_____ _____

Signature of Patient/Responsible Person Date

_____

Printed Name of Signer

Rev.02/04/17

Patient Name: _____ **Date of Birth:** ____/____/_____

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.

SPECIFIC AUTHORIZATIONS:

I give Living Pure Chiropractic, LLC permission to use my address, phone number, email address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards/emails, holiday related cards/emails and information about treatments alternatives or other health related information.

If Living Pure Chiropractic, LLC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

PLEASE TURN OVER...

Patient Name: _____ **Date of Birth:** ____/____/_____

I give Living Pure Chiropractic, LLC permission to post any testimonial I provide and/or photo on the specific media channels I indicate on the signed media release form.

I give Living Pure Chiropractic, LLC permission to treat me in an open room where other patients are also being treated. I am aware that other persons I the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private he/she will provide a room for private conversations.

By signing this form you are giving Living Pure Chiropractic, LLC permission to use and disclose your protected health information in accordance with the directives listed above.

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. A copy of this signed authorization will be provided to you if requested.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Signer

Patient Name: _____ **Date of Birth:** ____/____/_____

Informed Consent for CHIROPRACTIC Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method to be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed of the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal, physical and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance of the nervous system. This occurs when one or more of the 24 vertebra in the spinal column become misaligned or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **Adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities. Adjustments are usually done by hand but may be performed by instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested. I authorize the Doctor to work with my condition through the use of chiropractic adjustments and or physical therapy modalities as he or she deems appropriate.

_____ _____ _____

Print Name Signature Date

Consent to adjust a minor child: I, _____ being the parent or legal guardian of_____ have read the fully understand the above informed Consent and herby grant permission for my child to receive chiropractic care at this office.

_____ _____ _____

Signature Print Name Date

Patient Name: _____ **Date of Birth:** ____/____/_____

Terms for Acceptance for Acupuncture

When a patient seeks acupuncture and we accept a patient for such care, it is essential for both to be working towards the same objective.

Acupuncture 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.

Acupuncture: The ancient Oriental art and science of inserting extremely fine needles into the body to open and unblock energy or "Qi". Acupuncturists may also use low voltage electrical instruments to stimulate acupuncture points. Acupuncture points are located on the body and are stimulated in such a way as to increase or decrease the flow, or even re-direct the flow of energy in the body.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose, treat any disease or condition. However, if during the course of our examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend 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 the treatment of others. OUR ONLY PRACTICE OBJECTIVE is to facilitate the movement of "Qi". When the "Qi" is deficient, illness results. When the Qi is in excess or becomes stagnant there will almost always be pain. But when the "qi" is abundant and free-flowing the body is balanced and harmonious.

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested. I authorize the Doctor to work with my condition through the use of acupuncture as he or she deems appropriate.

I, _____ have read and fully understand the above statements.
(Print Name)

_____ _____
(Please Sign) (Date)

Living Pure Chiropractic, LLC Doctor's Name: _____

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Specific LOCATION of Crash/Accident: _____

Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow/Hail

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Rear Left ☐ Rear Right ☐ Rear Center ☐ Pedestrian ☐ Other: _____

Please describe how the collision happened: _____

_____

_____

_____

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

Did the airbags deploy? **Yes / No** If Yes, were you struck? **Yes / No** Burned? **Yes / No**

Did you strike another vehicle? **Yes / No**

If Yes, what part of the other vehicle did you strike? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side

Did another vehicle strike your vehicle? **Yes / No**

If Yes, were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Second Collision:

Did your car strike any objects or other vehicles AFTER you were hit? ☐Yes ☐No

If Yes, please describe: _____

1) In relation to the back of your head, was your headrest set: **Low / Middle / High**

2) Were you surprised by the impact? **Yes / No**

If "NO", how did you brace? **With Hands / With Feet**

Were your brakes applied at impact? **Yes / No**

3a) Where was your head facing at the time of impact? **Straight Ahead / Left / Right / Behind**

3b) Were you leaning forward at the time of impact? **Yes / No**

4) Were you wearing hat or sunglasses? **Yes / No** If yes, were they still on after the impact? **Yes/No**

5) Were any contents within your vehicle shifted as a result of the impact? **Yes / No**

6) What type and year of vehicle were you in? _____

6a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

7) What type and year of vehicle that struck yours? _____

7b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

8) Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

9) Did you feel pain immediately after the accident? **Yes / No**

10) Were you rendered unconscious as a result of the accident? **Yes / No**

11) Did you strike anything inside the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other**: _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing / Walking / Riding / Bending / Twisting**

Do you have difficulty in excessive lifting: **Light / Moderate / Heavy / Repetitive**

Symptoms other than above: _____

_____ _____

Patient Signature Date