WESTSIDE PAIN CLINIC

"From Pain to Performance"

Welcome

PATIENT

TITLE: ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR. ☐ OTHER _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER _____

FIRST NAME M.I. LAST NAME

DATE OF BIRTH GENDER: ☐ MALE ☐ FEMALE SOCIAL SEC. #:

STREET ADDRESS CITY ST ZIP

PHONE NUMBERS

HOME WORK CELL

EMAIL ADDRESS

SPOUSE / EMERGENCY CONTACT

FIRST NAME M.I. LAST NAME

PHONE NUMBERS

HOME WORK CELL

EMPLOYMENT / INSURANCE ☺ *PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD* ☺

STATUS: ☐ EMPLOYED ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ FT/PT STUDENT ☐ MILITARY ☐ RETIRED ☐ DISABLED

NAME OF EMPLOYER OCCUPATION

WHO IS RESPONSIBLE FOR YOUR BILL?

☐ SELF ☐ HEALTH INSURANCE ☐ SPOUSE ☐ WORKER'S COMP ☐ AUTO INS. ☐ MEDICARE ☐ OTHER _____

PRIMARY CARE PHYSICIAN

☐ **WORKPLACE INJURY**

HAVE YOU FILED AN INJURY REPORT WITH YOUR EMPLOYER? ☐ YES ☐ NO DATE:

☐ **AUTO INJURY**

HAVE YOU SUPPLIED US WITH THE AUTO ACCIDENT REPORT AND LEGAL REPRESENTATION INFORMATION? ☐ YES ☐ NO

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and/or have been given the opportunity to review Westside Pain Clinic's Notice of HIPAA Privacy Practices for protected health information.

PATIENT'S NAME (PLEASE PRINT) DATE

PATIENT'S SIGNATURE

CONSENT TO TREAT A MINOR

NAME OF MINOR PATIENT DATE

SIGNATURE OF PARENT / GUARDIAN AUTHORIZING CARE

How did you hear about our practice? _____

FEMALE PATIENTS: Do you believe you may be pregnant? ☐ YES ☐ NO ☐ NOT SURE

PATIENT SELF-ASSESSMENT - 1

PATIENT NAME_____ DATE _____

SYMPTOM MAP

Mark the areas where you are experiencing symptoms.

Use the key letters to indicate type of discomfort.

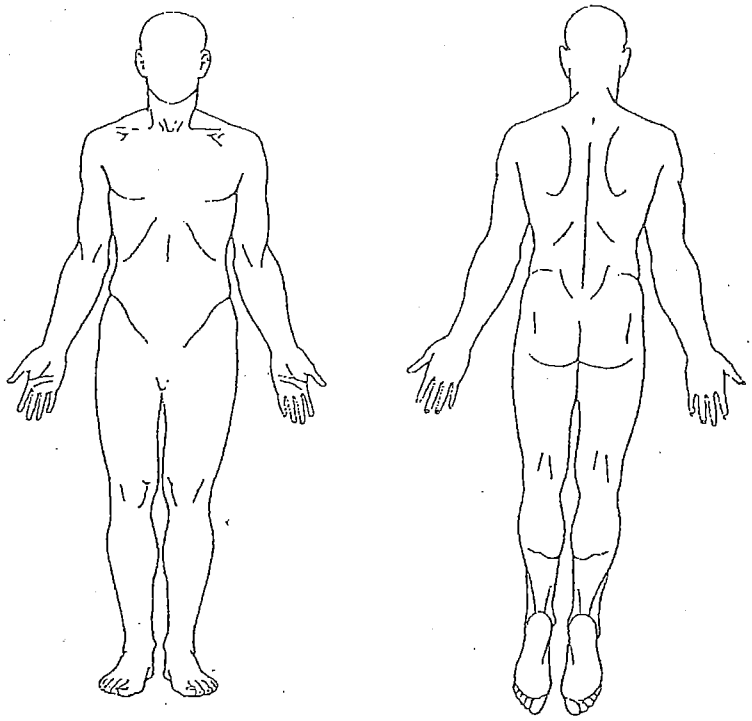
N - NUMBNESS

B - BURNING

S - STABBING

T - TINGLING

A - ACHE



When did symptoms begin? _____

Briefly describe your symptoms: _____

_____

How did your symptoms begin? _____

_____

Rate the average severity / intensity of your pain:

Last 24 hours:	NO PAIN	0	1	2	3	4	5	6	7	8	9	10 WORST PAIN
Past week:	NO PAIN	0	1	2	3	4	5	6	7	8	9	10 WORST PAIN

How much of the time do you experience your symptoms?

☐ 75 - 100 % ☐ 50 - 75% ☐ 25 - 50% ☐ 0 - 25%

How much do your symptoms interfere with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How would you describe the state of your symptoms over time?

☐ Much worse ☐ Slightly worse ☐ No change ☐ Slightly improved ☐ Much improved

How would you describe general state of your health right now?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Authorization for Treatment and Informed Consent

Prior to receiving care in this office, a health history and physical examination will be completed. These procedures are performed to assess specific conditions, overall health, and spinal health. These procedures will assist in determining if chiropractic care is needed or if any further examination is needed. In addition, they will help determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care. Chiropractic care, like all forms of healthcare, while offering considerable benefits has some level of risk. The level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with cervical spine (neck) adjustments, which occurs at a rate between one instance per one million to one instance per two million, may be a vertebral artery injury that could lead to stroke. I hereby authorize chiropractic treatment by GNR Chiropractic LLC ("GNR Chiropractic"), its chiropractors and chiropractic assistants. I recognize that I may, at any time, participate in and make decisions regarding my care, including the right to accept or refuse treatment.

Appointment Policy

The frequency of visits are scheduled and determined according to the severity of the condition in conjunction with your schedule and the recommendation of the provider. The frequency of visits effects results, so we ask each patient assume responsibility of adhering to each appointment for optimum results. If you are unable to keep an appointment please contact us immediately to reschedule. This office reserves the right to charge for missed appointments and those cancelled without twenty-four hours notice. We sincerely attempt to honor all appointments at the scheduled time. If you are late, we may ask that you wait for the next available appointment time so as not to delay others.

Authorization to Release Information and Assignment of Benefits

I hereby authorize payment directly to GNR Chiropractic for any and all payments/benefits due from or payable by any insurance company or third-party payer for services rendered by providers at this office. I hereby authorize GNR Chiropractic to use and disclose any information necessary to process my claims or obtain payment for services rendered by the provider(s) from my insurance company, third party agency, or other payer in a manner consistent with HIPAA. I understand that GNR Chiropractic LLC does not accept responsibility of collecting my insurance benefits or negotiating a settlement for a disputed claim.

Insurance Policy and Financial Agreement

I understand that I am fully responsible for and I agree to pay for all services rendered. I understand that if this office bills my insurance or other third-party payer, I am ultimately financially responsible and liable for any amounts not paid including all deductibles, co-pays, co-insurance, or non-covered services except for amounts deemed contractually uncollectible by insurance companies with whom GNR Chiropractic is contracted. Further, this office does not promise that an insurance company will reimburse for the usual and customary charges submitted. I understand that payments made by me that are collected prior to insurance or third-party payer adjudication are deemed estimates and my balance may differ upon insurance or third-party payer adjudication. I agree to pay all unpaid amounts no later than thirty (30) days following payment from my insurance company or third party payer. If my insurance or third party payer fails to pay my account within ninety (90) days from the date it was billed, I agree it is my responsibility to pay my account balance or make financial arrangements for full payment. If I do not have insurance or a third-party payer, I agree to pay all amounts due at the time of service or at the end of each week. I understand that if my account balance is not paid as agreed above, my account balance may be transferred to a third party collection agency. If that occurs, I agree to pay for all costs of collection, including but not limited to court costs, reasonable attorneys' fees, and interest at a rate allowed by law. I am responsible for all incurred fees associated with a returned check. If during my care, my insurance company or third-party payer changes, I agree to notify this office within 15 days of the effective date.

Privacy Notice

My signature below constitutes my acknowledgement that I have been provided a copy of this office's notice of privacy practices pursuant to HIPAA which describes how my healthcare information is used and shared with others. I understand my rights and responsibilities as they relate to the privacy notice. I understand that GNR Chiropractic reserves the right to change the privacy notice at any time and a current copy is available upon request.

By signing below I acknowledge that I have read the document above including all agreements, policies, and statements, and fully understand and agree to comply with its provisions.

Patient/Responsible Party Signature _____ Date_____

Printed Name _____ Relationship to Patient _____