

Soldano Family Chiropractic Center

1324 S Park St Suite #3 Kalamazoo, MI 49001 · phone (269)381-2800 · fax (269)381-2808

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is specific adjustments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral Subluxations.

I _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _____ Date _____

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PAYMENT POLICY

There are two forms of payment:

CASH, CHECK OR CREDIT CARD – Every time you come in. After 60 days of non-payment, a \$25.00 late fee will be added to your account to be compounded monthly.

OR

INSURANCE ASSIGNMENT – Co-pay, insurance reimbursement signed over to our clinic (as explained below).

Please check how you wish to pay: CASH CHECK CREDIT CARD

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and a supportive heal care program is recommended. We will notify you of the change.
2. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
3. The insurance carriers are billed on specific 15-30 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
6. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

Patient Signature _____ Date _____

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CHIROPRACTIC INSURANCE VERIFICATION

Our office is set up to utilize direct payment from insurance companies. This is done as a service to our patients and there is no charge for this service. However, it is important that you understand that health and accident insurance policies are an arrangement between you and your company. You are personally responsible for all service charges incurred in our office. We expect payment in full when services are rendered.

Patient's name _____

Please fill out this form and return it to our office at your next visit. **HERE IS WHAT YOU DO TO VERIFY COVERAGE FOR CHIROPRACTIC CARE:**

DATE you called your insurance company _____
NAME of the person who gave you information _____ Job Title _____

1) CALL your insurance company and ask the following questions:

a) Does my policy cover Chiropractic? ___ Yes ___ No

If yes, are there limits to my coverage? ___ Yes ___ No

What are those limits? (Be as specific as possible): _____

Will they cover: Cervical Supports? ___ Yes ___ No Spinal Traction? ___ Yes ___ No

Nutritional Supplements? ___ Yes ___ No Structural Supports? ___ Yes ___ No

Is there a limit to the number of visits allowable? ___ Yes ___ No If yes, how many? ___

b) What is the Deductible? _____ Is that yearly? _____

Has it been paid? ___ Yes ___ No If yes, How much? _____

Is there a Family deductible? ___ Yes ___ No If so, how much? _____

Is there a carry-over? ___ Yes ___ No If so, how long? _____

c) What percentage of my bills will my policy cover? _____

d) What is the effective date of my policy? _____

e) Can my benefits be assigned to my chiropractor's office? _____

f) What is the address of the office where the claims are sent? _____

g) To whose attention is the claim sent? _____

h) PHONE NUMBER of insurance company? _____

i) POLICY NUMBER _____

Individual policy? ___ Yes ___ No Group Policy? ___ Yes ___ No

Name policy is under _____

j) Please check the one that applies to your case:

___ Major Medical ___ Personal Injury ___ Auto Accident

___ Industrial accident/worker's Compensation

- 2) Obtain Insurance form from your agent or place of employment. Fill in the required personal information. Where applicable, have your employer fill in the indicated section then bring the form to our office. This questionnaire and your insurance form should be brought to our office within two weeks of your first visit. Once your coverage is confirmed we may accept payment directly from the insurance company.
- 3) If you have any questions or problems, please direct them to the office staff.

The above statements and answers are true,

Patient's Signature

Consent for Purpose of Treatment, Payment and Healthcare Operations

I acknowledge that Soldano Family Chiropractic Center's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Soldano Family Chiropractic Center's Notice of Privacy Practices prior to signing this document. Soldano Family Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Soldano Family Chiropractic Center. The Notice of Privacy Practices for Soldano Family Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Soldano Family Chiropractic's duties with respect to my protected health information.

Soldano Family Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Name of Person(s) Authorized to Gain Access to Account Information

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EMERGENCY CONTACT SHEET

Patient's Name _____

1st Contact _____

Address _____

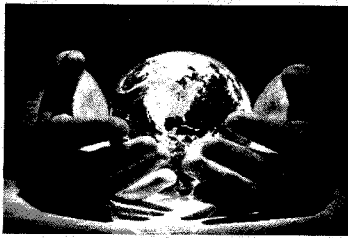
Phone _____

2nd Contact _____

Address _____

Phone _____

Case History



PREPARED FOR

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Loss of Wellness (Birth – Age 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

| Yes | No | (Birth – Age 5) | Patient Comment (if answer is Yes) | Chiropractor's Comments |
|--------------------------|--------------------------|---|---------------------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Pregnancy | | |
| | | <i>Did your mother:</i> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke or drink alcohol? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a proper diet? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise through her pregnancy? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Experience any falls and injuries during pregnancy? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Experience any physical and/or mental abuse? | _____ | _____ |
| | | 2. Birth Process | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the delivery long? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Was the delivery difficult? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Forceps? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Caesarean? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Breach/cephalic? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Home birth? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital birth? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mother given drugs during delivery? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Was labor induced? | _____ | _____ |
| | | 3. Growth and Development | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you taught how to care for your spine? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you roll out of bed? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you a headbanger or rocker? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you breast fed? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Childhood sicknesses? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Accidents? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drugs? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you fall while learning to walk? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you picked on by siblings? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Child abuse | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Spanking (how?) | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulled ear/chin | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chair pulled out when sat down? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you fall down stairs? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you yanked by your arm? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have other traumas? What? When? | _____ | _____ |

Loss of Whole Body Health (Age 5 - present)

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

| | | | Patient Comment (if answer is Yes) | Chiropractor's Comments |
|--------------------------|--------------------------|---|---------------------------------------|-------------------------|
| Yes | No | (Age 5 - Present) | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you taught proper body movement and care? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did/do you smoke? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did/do you drink any alcohol? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diet (Do you eat healthy foods?) | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been in accidents? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had surgery and organs removed/replaced? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drugs? (Prescriptive or non-prescriptive) | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Teeth problems? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye problems? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise regularly? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping habits (nightmares?) | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Did/do you have occupational stress? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical stress? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental stress? | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hobbies/Sports injuries | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other traumas or problems | _____ | _____ |

Symptoms and Ill Health (Present State of Ill Health)

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Feet Cold | |

PRESENT COMPLAINT

Major complaint: _____

Pain or Problem started when: _____

Pains are: Sharp Dull Constant Intermittent Is condition getting progressively worse? Yes No

What activities aggravate your condition/pain? _____

Is condition worse during certain times of the day? Yes No If so, when? _____

Is this condition interfering with (circle those that apply): Work? Sleep? Routine? Other: _____

Other doctors seen for this condition: _____

Any home remedies? _____

Symptoms and Ill Health (cont'd)

Have you been under drug and medical care? Yes No

If yes, please explain: _____

What medications are you taking? _____ How long? _____

Have you had surgery? Yes No

FAMILY HISTORY

For what? _____

Father's Side

Mother's Side

When? _____

Heart Disease

Heart Disease

What side effects (if any) did you experience from the drugs and surgery?

Arthritis

Arthritis

Cancer

Cancer

Diabetes

Diabetes

Other: _____ Other: _____

Patient Information

Name: _____ Social Security #: _____ Date: _____

Gender: Male Female Date of Birth: _____ (Age: _____) If you were referred, by whom? _____

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

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Occupation: _____ Employer: _____

Marital Status: S M D W Spouse's Name and Occupation: _____

Number of Children and Ages: _____

Have you ever received Chiropractic care? Yes No

Have you ever been in an accident? Yes No Work Auto Other: _____

Nature of Accident: _____ When? _____

Did you feel a popping or tearing noise in your neck or back? Yes No

Did you require post-accident hospitalization? Yes No

Where? _____ When? _____ Were X-rays taken? Yes No

Did you lose days at work as a result? Yes No How many? _____

Is insurance involved? Yes No _____ Which company? _____

Attorney's name: n/a _____ Claim #: _____

Comments (office use only): _____