

Confidential Patient Health Record

DATE: _____ ID# _____

PLEASE DO NOT LEAVE ANY BLANKS, IF SOMETHING DOES NOT APPLY WRITE N/A.

PERSONAL HISTORY

Name: _____ Address: _____

Zip: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Gender: Male Female

Birthdate: _____ Age: _____ Social Security #: _____

Circle One: Married Single Widowed Divorced Separated Email Address: _____

Is anyone at your current address already on our mailing list? _____

How were you referred to this office? _____

Cell#: _____ Employer: _____

Type of Work: _____ Are you active or retired? _____ Number of children: _____

Spouse Information: Name: _____ Birthdate: _____

Social Security#: _____ Employer: _____

Is spouse active or retired? _____ Work#: _____

Name and number of Emergency Contact: _____

Name of PRIMARY Insurance: _____ SECONDARY: _____

Is your insurance (other than Medicare) provided by an employer or an ex-employer? _____

or is your insurance purchased by self/spouse? _____

HISTORY OF COMPLAINT

Chief Complaint: _____

Other Doctors seen for this condition: _____

Diagnosis: _____

Type of treatment: _____ Results: _____

Is condition: Job related Auto related Home Injury Fall Other

Date of Accident: _____ Time of accident: _____

Have you made a report of your accident to your employer? _____

Do you wear a shoe lift? _____ In which shoe? _____

Medications you are presently taking? _____

Do you suffer from any other condition other than your chief complaint? _____

PAST HEALTH HISTORY

Surgical History: _____

List Broken bones: _____

Major accidents or falls: _____

Hospitalization (other than above): _____

Previous Chiropractic care: _____

.(turn page)

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES/SYMPTOMS YOU HAVE HAD;

- | | | |
|-----------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | |

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing
- Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostrate/Sexual Dysfunction

FEMALES ONLY;

When was your last period? _____
 Are you pregnant?
 Yes No Not Sure

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure
- Irreg. Heartbeat
- Heart Problems
- Lung Problems
- Lung Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

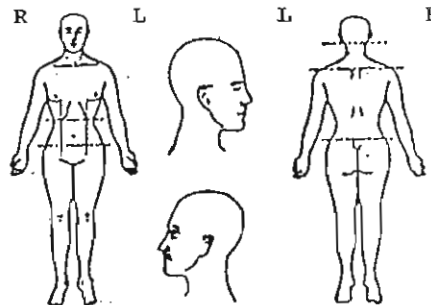
GENITO-URINARY

- Bladder Trouble
- Painful Urination
- Excessive Urination
- Discolored Urine

INDICATE ABILITY TO PERFORM THE FOLLOWING:
 Use codes: U=unable P=painful L= Limited
 D=difficult N=Normal

- | | |
|---|--|
| <input type="checkbox"/> Coughing or sneezing | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Bending forward | <input type="checkbox"/> Balancing |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Dressing Self |
| <input type="checkbox"/> Walking short distances | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Stooping |
| <input type="checkbox"/> Sitting at a table | <input type="checkbox"/> Gripping |
| <input type="checkbox"/> Lying on back | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Lying on stomach | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Lying on side/knees bent | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Bending to brush teeth | <input type="checkbox"/> Sexual Activity |

SHADE AND CODE AREA(S) TO INDICATE
 PAIN OR DISCOMFORT:
 P=Pain N=Numb S=Spasm T=Tender



What else aggravated your pain? _____

 What relieves your pain? _____

VISUAL ANALOG SCALE

FOR LOW BACK PAIN

The line below represents the intensity of low back pain.
Please mark an "X" at the position on the scale which indicates
how much pain you feel in your low back AT THIS TIME.

No Pain _____ Worst Pain
Imaginable

FOR PAIN OTHER THAN LOW BACK PAIN

No Pain _____ Worst Pain
Imaginable

Authorization And Assignment

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

Date _____ Signed _____

**INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT**

Based on your medical history, physical examination, and diagnostic studies at Center Line Chiropractic Life Center, a course of chiropractic therapy is recommended. Treatment may include, but is not limited to: chiropractic manipulative adjustments, Cox flexion distraction, hot and/or cold therapy, bracing, accupressure, stretching and/or stretching exercises and nutrition. Treatment is expected to last one to three months.

Center Line Chiropractic Life Center believes this recommended therapy to be reasonable and necessary and the anticipated benefits to far outweigh the risks, some patients understandably wonder what complications might occur.

For the vast majority of patients, there are few, if any risks, and most of the risks are minimal, such as spinal or extremity pain. In some patients, more serious complications, such as sprains/strains, disc herniation (rupture), paralysis of the legs and organs, dislocations, fracture or vascular accident, may occur. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you may be referred immediately to another physician for surgery or other treatment.

Center Line Chiropractic Life Center is staffed by four chiropractic physicians, and as such, all patients may be examined and treated by the other doctors so as to facilitate the regularity and consistency of care as well as to render a second opinion of your diagnosis and treatment.

This consent is designed to inform rather than to frighten you. Thus, if you have any questions, Drs. Manteuffel, and Dr. Wrobel will be glad to discuss them with you before beginning treatment.

Sincerely,

Center Line Chiropractic Life Center
Mark D. Manteuffel, D.C.
Laurence J. Manteuffel, D.C.
Ronald J. Manteuffel, D.C.
Mark R. Wrobel, D.C.

I have read and understand the above consent form and I understand the recommended treatment. I understand and consent to the treatment being delivered by either Mark D. Manteuffel, D.C., Laurence J. Manteuffel, D.C., Ron J. Manteuffel, D.C., or Mark R. Wrobel, D.C. I nonetheless give my consent to Center Line Chiropractic Life Center, to provide the recommended chiropractic therapy. No guarantee or assurances of results have been made.

Date

Patient Signature

Witness Signature

Center Line Chiropractic Life Center

26672 Van Dyke
Center Line, MI 48015



The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR VISA/MASTERCARD AND DISCOVER CARD.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a provider we are willing to bill your insurance company for you. Waiting for payment is a courtesy provided by this office, we reserve the right to withdraw this courtesy at any time.

We contact your insurance company to determine if chiropractic is a benefit on your policy. When your insurance company quotes benefits, they also quote a disclaimer: "Description of coverage is not a guarantee of payment, coverage and eligibility is based on date of service and claims will be considered for payment when received." If your insurance company will not guarantee payment, NEITHER WILL WE !! In the event that the insurance company disputes or rejects the claim, it will be your responsibility to pay the charges and pursue reimbursement from your insurance company. To be fair, we will do our best to get the correct benefit information. But, ultimately, the responsibility for payment is YOURS.

Many insurance companies contact the patient after we send your claims to them. They are usually requesting accident information and seeking other insurance information. If you do not respond to their request, they will not process your claim. If you receive payment from your insurance company, instead of them paying us, we expect you to bring in the check and the explanation of benefits that is attached to it. FAILURE TO DO SO WILL RESULT IN COLLECTION ACTION.

MINOR PATIENT: The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a Visa or Mastercard, or payment by cash or check at the time of service. Parent or guardian must sign a permission slip on behalf of the minor.

Barbara Stanley handles the insurance in this office and all inquiries, billing verification and problems will go thru her.

Thank you for reading our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy and I understand and agree to this Policy.

X _____ DATE _____
Signature

Clinic C.A. initials

MISSED APPOINTMENTS:

**A 24 HOUR NOTICE WILL BE NECESSARY TO
AVOID A \$30.00 MISSED APPOINTMENT FEE.**

FAX (586) 756-8279
PHONE (586) 756-7670

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND
HEALTHCARE OPERATIONS**

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

I understand I have a right to review Centerline Chiropractic Life Center's Notice of Privacy Practices prior to signing this document. 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 Centerline Chiropractic Life Center. The Notice of Privacy Practices for Centerline Chiropractic Life Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Centerline Chiropractic Life Center's duties with respect to my protected health information.

Centerline Chiropractic Life Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Centerline Chiropractic Life Center has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority