

MOSES FAMILY CHIROPRACTIC AND WELLNESS CENTER

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

PATIENT NAME

DATE COMPLETED

REGISTRATION

Date: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Phone (home): _____ Phone (cell): _____ Phone (work): _____

Email address: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Drivers License #: _____

Primary Care Physician: _____

Specialist Physician: _____

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands
right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms
right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs
right/left

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: yes _____ no _____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
------------	---	---	---	---	---	---	---	---	---	---	----	----------------------

Patient Name: _____ Date: _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

P = PINS & NEEDLES

G = STABBING

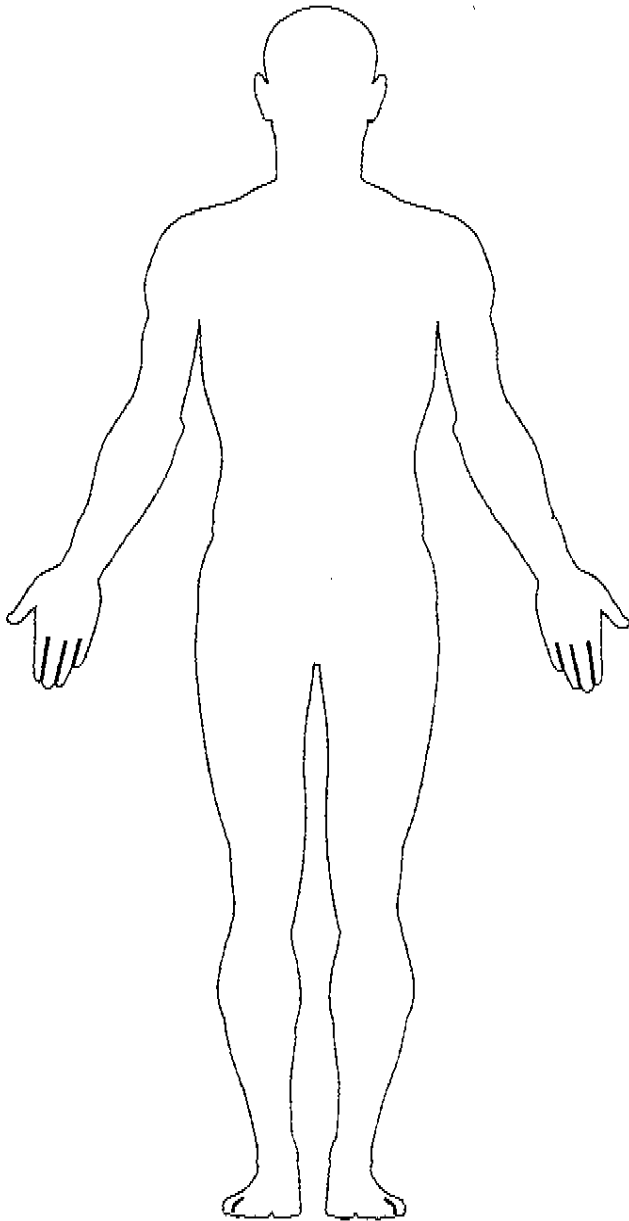
M = SPASMS

F = STIFFNESS

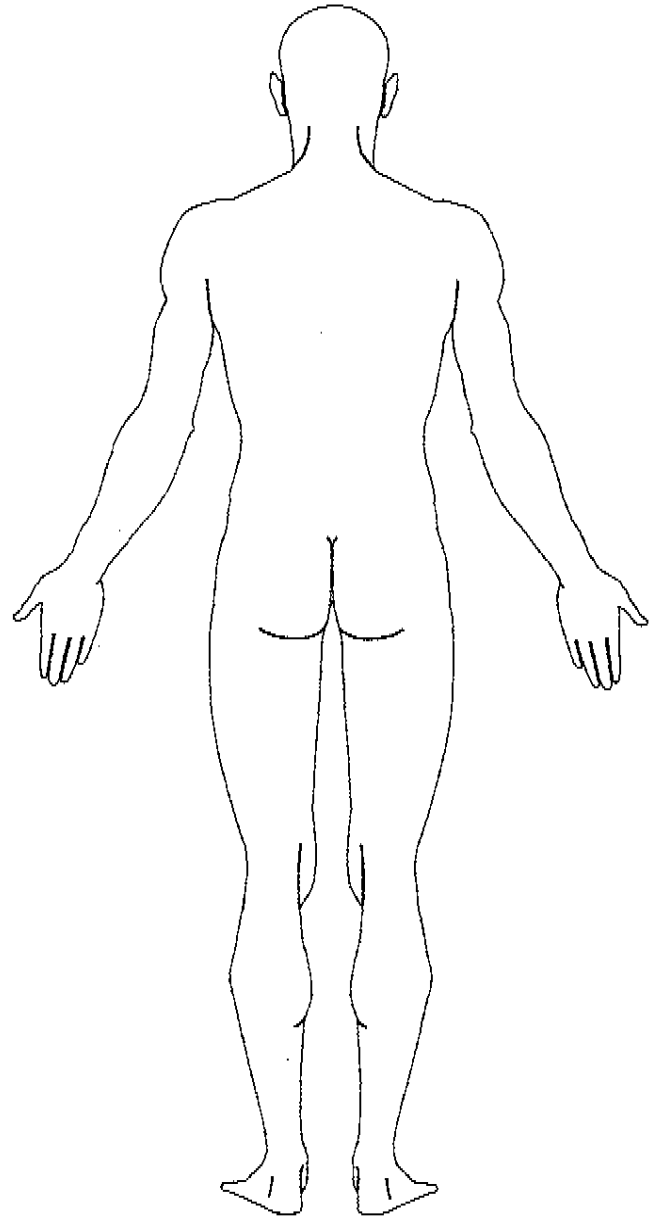
N = NUMBNESS

T = TINGLING

O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|---|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Patient Name: _____ Date: _____

Gastrointestinal Disorders

- | | | |
|--|---|---|
| <input type="checkbox"/> peptic ulcer or stomach ulcer | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> hepatitis - Type _____ |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> irritable bowel | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> GI bleed | <input type="checkbox"/> inflammatory bowel disease | |
| <input type="checkbox"/> other: _____ | | |

Genitourinary Disorders

- | | | |
|--|--|---|
| <input type="checkbox"/> urinary tract infection | <input type="checkbox"/> kidney problems | <input type="checkbox"/> dialysis, kidney failure |
| <input type="checkbox"/> bladder problems | <input type="checkbox"/> kidney stones | <input type="checkbox"/> other: _____ |

Metabolic & Other Disorders

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes x _____ years | <input type="checkbox"/> skin disorder _____ | <input type="checkbox"/> depression |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> psoriasis | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> any skin ulcer | <input type="checkbox"/> alcohol or drug dependency |
| <input type="checkbox"/> high cholesterol or lipids | <input type="checkbox"/> tooth abscess, gingivitis | <input type="checkbox"/> other: _____ |

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Family History:

Please indicate with an "X" any significant family medical history or problems.

- | | | |
|--|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> COPD or Emphysema | <input type="checkbox"/> other lung : _____ | |
| <input type="checkbox"/> heart attack, myocardial infarction | <input type="checkbox"/> congestive heart failure | |
| <input type="checkbox"/> irregular heartbeat, arrhythmia | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> MS or Parkinson's | <input type="checkbox"/> other neuro : _____ | |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> Lupus | <input type="checkbox"/> gout |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> Other bone & joint: _____ | |
| <input type="checkbox"/> acid reflux, GERD | <input type="checkbox"/> inflammatory bowel disease | <input type="checkbox"/> hepatitis - Type _____ |
| <input type="checkbox"/> liver disease | <input type="checkbox"/> other GI : _____ | |
| <input type="checkbox"/> kidney problems | <input type="checkbox"/> dialysis, kidney failure | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> psoriasis | <input type="checkbox"/> high cholesterol or lipids |
| <input type="checkbox"/> thyroid problems | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> any skin ulcer |
| <input type="checkbox"/> Malignant hyperthermia | | |

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Patient Name: _____ Date: _____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay: **Moses Family Chiropractic & Wellness Center, P.C.** 58851 Van Dyke Rd., Suite 300 Washington, MI 48094, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. **If I fail to make payment or payment arrangements, any unpaid balance I owe older than 90 days may be turned into collections, and a 35 – 50% collections fee will be added to my outstanding balance.**

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been or will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ 20 ____.

X _____

(Patient signature)

(Please print patient name)

X _____

(Signature of Guardian if applicable)

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: _____

Acknowledgement of Receipt of Privacy Practices

Moses Family Chiropractic

Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you received a copy of this notice.

Print Name (Last, First, Middle Initial)

Signature

Date

About Your Insurance

Due to the constant changes in insurance, it is no longer an easy task to interpret/verify each individual policy. We have run across automated systems that give us one set of benefits, and when talking with an agent/representative of that company, get another set of benefits that DO NOT match. Although we do our best to stay aware of any changes, it is not always possible. It is YOUR responsibility to know your individual coverage.

Please remember that almost ALL insurance policies have exclusions, what insurance refuses to cover (even though you pay the insurance company premiums every month, they do this for their economic gain, and are NOT concerned about your individual health care needs are. But they DO care that you pay your premiums every month). MOST policies have deductibles, and co-payments and/or co-insurance payments. Your treatments at our office are based on YOUR SPECIFIC NEEDS to get you the BEST RESULTS POSSIBLE, and are NOT based on what your insurance may or may not pay for. (If you are unwilling to pay for services that are not covered, but recommended by the doctor to get you the best results, please inform the doctor and/or staff).

Please remember that your insurance policy is an agreement between YOU (the one paying the premiums) and your insurance company. It is NOT AN AGREEMENT BETWEEN THE INSURANCE COMPANY AND THE DOCTOR.

If you have any questions or concerns about your insurance at any time, please ask the doctor or staff. We are happy to help however we can.

Thank you for your time and understanding.

Jack Moses, D.C. & staff

_____ Patient/parent/guardian signature

_____ Date