☐ **Phillip Snell, D.C.** Chiropractic Physician ☐ **Scott Haines, D.C.** Chiropractic Physician ☐ **Cory Peterson, D.C.** Chiropractic Physician

☐ **John Parker, D.C.** Chiropractic Physician ☐ **Sheri Blue, LCSW, CADC I, LMT** Counseling, Therapeutic Massage

☐ **Taya Lindley, L.Ac.** Licensed Acupuncturist ☐ **Eva Hosseinion, L.Ac.** Licensed Acupuncturist ☐ **Kelly Owens, ND** Naturopathic Doctor

☐ **Aimee Perkins, LMT** Therapeutic Massage ☐ **Sara Armstrong, LMT** Therapeutic Massage

Hawthorne Wellness Center

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The following information is needed for our files so we can better serve you as a patient. Please fill in ALL portions of the form. PLEASE PRINT CLEARLY. Thank you.

Patient Information

Patient's Name: _____ Nickname: _____ Date: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ E-MAIL: _____

Employer: _____ Work #: _____ Occupation: _____

Age: _____ Date of Birth: _____ Legal Gender: _____ Preferred Pronouns: _____

Marital Status (Circle One): S P M D W Number of Children & Ages: _____

Referred to this clinic by: _____

THIS PATIENT IS A MINOR. PERMISSION IS HEREBY GIVEN BY ME TO THE PROVIDERS OF THIS CLINIC TO EXAMINE AND TREAT THE PATIENT.

Signature: _____ Printed Name: _____ Date: _____

Insurance Information

Who are we billing? ☐ Self Pay/Not Billing Insurance ☐ Auto Insurance ☐ Workers' Compensation ☐ Personal Insurance

Primary Insurance Company Name: _____ Phone # (back of card): _____

Policy/ID #/Claim #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Emergency Contact Information

Name: _____ Relationship: _____Phone:_____

I give my consent for Hawthorne Wellness Center to contact the above named person in case of an emergency.

Signature: _____ Date: _____

Appointment Reminders

Please choose **ONE** of the following options: ☐ Voice Message ☐ E-Mail ☐ Text Message ☐ No Reminder

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Case History Record-Chiropractic

Name_____

Date_____Date of Birth_____Age_____

CHIEF COMPLAINT-Briefly describe current problem(s)

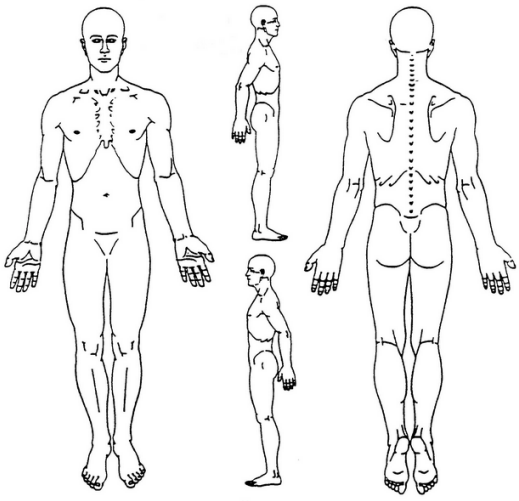
_____

_____

_____

When did this begin?_____

Please mark areas of pain, tightness or symptoms



SYMPTOMS

What makes it better?_____

What makes it worse?_____

Are symptoms getting better or worse?_____

Rate your pain on the scale below (circle)-

(none) 0 1 2 3 4 5 6 7 8 9 10 (Worst imaginable)

Describe your pain (circle): Sharp Dull Burning Electrical Throbbing Constant Intermittent

PREVIOUS CARE FOR PRESENT CONDITION

Xrays?_____MRI?_____Lab work?_____

Other_____

Who are your other healthcare providers (please provide contact information/address)?

Primary Care Physician:_____

Specialist:_____

Chiropractor:_____

Physical therapist:_____

Other:_____

Other:_____

PRIOR SURGERIES (list dates for each)

_____Date_____ _____Date_____

_____Date_____ _____Date_____

CURRENT MEDICATIONS & SUPPLEMENTS

Product_____Condition_____ Product_____Condition_____

Product_____Condition_____ Product_____Condition_____

Product_____Condition_____ Product_____Condition_____

PAST MEDICAL HISTORY (Circle all that apply)						
Neuro	Migraine	Tingling feet/hands	Seizures	Shingles	Sciatica	Stroke
Endocrine	Diabetes	Hepatitis	Menopause	High cholesterol	Obesity	
Respiratory	Asthma	Emphysema	Pneumonia	Seasonal allergy	TB	Sinusitis
Cardiac	Heart attack	High blood pressure	Murmur	Arrhythmia	Stent	Valve disorder
GI	GERD	Hemorrhoids	IBS	Gluten sensitivity	Constipation	Gallstones
Vascular	Blood clots	Atherosclerosis	Embolism	Aneurysm	Anemia	Dizziness
Ortho	Osteoarthritis	Fibromyalgia	Osteoporosis	Gout	Hernia	Disc injury
GU	Kidney stones	Bladder infections	Nephritis	Menstrual disorder	Prostatitis	STD
Psych	Depression	Anxiety	Panic	OCD	Bipolar	Addiction
Immune	Rheumatoid	HIV	Thyroiditis	MS	Psoriasis	AS
Cancer	Type and treatment?					
Other	Any other conditions not mentioned?					

FAMILY HEALTH HISTORY-List any known cancers, causes of death, immune disorders, heart disease, etc. in your:

Parents:_____ Grandparents:_____

Aunts/Uncles:_____ Grandparents:_____

Brothers/Sisters_____ Grandparents:_____

SOCIAL/LIFESTYLE HISTORY

Marital Status_____ Children_____ Who do you live with? _____

Do you feel safe in your home? Y/N _____Highest education level_____

Employment_____

Sport/Exercise_____

Sleep quality_____ Special diet?_____

Tobacco_____pk/day___yrs Alcohol intake and frequency_____drinks, per _____

DO YOU HAVE ANY SPECIFIC HEALTH GOALS WE CAN HELP YOU WITH?

NOTES:

PATIENT: "My signature below reflects that the above information is true and correct to the best of my knowledge."

Patient signature_____Date_____

(If appropriate) Parent or legal guardian_____Date_____

FINANCIAL POLICY AND AGREEMENT

Cancellation & Missed Appointment Fees

A 24-hour notice is required for appointment cancellations. If we do not receive a 24-hour notice, you will be charged a $60 appointment cancellation fee. A $60 charge will be billed for all missed appointments.

Please **thoroughly read through the details of the method of payment that applies to you**, sign that you have read and agree to abide by the financial policy as listed below. Please also **initial** the method of payment box that pertains to you.

Self Pay/Not Billing Insurance

☐ Payment is expected at the time services are rendered. Cash, checks and credit cards (excluding American Express) are accepted for payment. An administrative discount is offered to patients who pay their account in full at the time of service, maintain a zero balance on their account and do not require insurance billing by this office.

Auto Insurance

☐ You must notify your insurance carrier of the accident and file a Personal Injury Protection (PIP) form with them. We will bill your auto insurance company. In the event the auto insurance check is sent to you, you are expected to bring the check to our office to be applied to your account. If for any reason your claim is denied or not paid in full by your insurance company, you will be responsible for your bill.

Workers' Compensation

☐ You must report your injury to your employer and fill out an injury report form (801) at your place of employment. We will bill your Workers' Compensation carrier. If for any reason your claim is denied or not paid in full, you will be responsible for your bill.

Private Insurance

☐ If you have insurance, which covers alternative care or mental health, we will bill your insurance company directly. Copays are due at the time of service. If you have a Coinsurance or Deductible, you will be billed upon receipt of the Explanation of Benefits from your insurance company. In the event the insurance check is sent to you, you are expected to bring the check to our office to be applied to your account.

- Verification of benefits is not a guarantee of payment by your insurance company.
- Any services not covered by your insurance plan are your responsibility. Services sometimes not covered by insurance may include, but are not limited to: TMJ/TMD Treatment, Fertility Treatment, Massage by a Licensed Massage Therapist.
- Some insurance plans have a separate benefit for each treatment code billed. Example: A chiropractic office visit, spinal manipulation and manual therapy codes might each have a separate benefit. Often manual therapy codes are applied to a deductible. It is YOUR responsibility to know your covered benefits.

I authorize my insurance company to make payment directly to this clinic for services rendered and permit this clinic to endorse co-issued remittances for the conveyance of credit to my account. **I understand this clinic will prepare any medical records, necessary forms and reports to assist me in making collection from my insurance company and that any amount paid directly to this clinic will be credited to my account upon receipt.** However, I clearly understand and agree that all services rendered are charged to me directly and that I am ultimately personally responsible for full payment. I agree to pay any costs or fees incurred in connection with the collection of my account, including attorney fees and court costs.

I have read, understand and agree to abide by the above financial policy that applies to me, including the Cancellation & Missed Appointment policy.

Signature: _____ Date: _____

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ACKNOWLEDGMENT AND CONSENT

I understand that **Hawthorne Wellness Center** (referred to below as "HWC") will use and disclose **health information** about me.

I understand that my **health information** may include information created and received by HWC, may be in the form of written or electronic records and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that HWC may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with cost-effective health care.

Notice of Privacy Practices describes my rights regarding my health information and the uses and disclosures of health information and the protocol followed by the providers and staff of HWC.

I understand that a copy or a summary of the most current version of HWC's Notice of Privacy Practices will be in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that HWC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

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Email Communication Consent Form

Your email will not be sold or shared. We will not be sending you any newsletters or advertisements. This is a HIPAA compliant form required in order to allow correspondence between you and your healthcare provider, as well as our staff and billing department, if you so choose. Here are some examples of email correspondence:

- Receive exercises from your chiropractor.
- Request supplements from your provider.
- Receive notifications from your provider upon supplement shipment arrival.
- Correspond with our billing department.
- Appointment reminders, if that is the method of reminder you have chosen.

Risks and Conditions of Using Email

I have been advised that:

- I may not use email to cancel or schedule appointments. All scheduling must happen via phone or in person due to an ever-changing scheduling calendar.
- Email is never appropriate for urgent or emergency problems.
- Emails should not be used to communicate sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, substance abuse, etc.
- All email correspondence will become a part of my health record. It is extremely important to include name and date of birth on each and every email to my healthcare provider. Since email may not be monitored while my healthcare provider is away on business or vacation, I will follow up by telephone or in person if I don't receive a response within a reasonable amount of time.
- Email is not confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their systems.
- There is not a way to assure the privacy of email on a shared computer or email account.
- Email communications travel across the public Internet. It is not possible to verify that email is actually received, opened and read by the addressee.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email as a form of communication between Hawthorne Wellness Center and myself. I understand that I may revoke this agreement at any time by contacting Hawthorne Wellness Center in writing.

Signature: _____ Date: _____

Name (Printed): _____

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