New Patient Information
Dr. Ronald G. Peterson Jr. D.C.

Demographic Information

Name _____ Date of Service _____

Address _____ Phone: (H) _____

City _____State _____ Zip _____ (W) _____

E-mail _____ Marital Status S M D W

Date of Birth _____ (Age _____)

Occupation _____ Employer_____

Spouse's Name _____ Spouse's Occupation _____

Emergency Contact _____
Name Phone # Relationship

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y N

Primary Care Physician _____
Name Address Phone #

How did you hear about Peterson Health Clinic LLC.? _____

Please check any and all insurance coverage that may be applicable in this case**:**

- ☐ Major Medical
- ☐ Worker's Compensation
- ☐ Medicare
- ☐ Auto Accident
- ☐ Medical Savings Account & Flex Plans
- ☐ Other

_____ _____
Signature Date

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E-mail us at: petersonhealthclinic@yahoo.com **Visit** us at: petersonhealthclinic.com

Chiropractic Case History/Patient Information

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

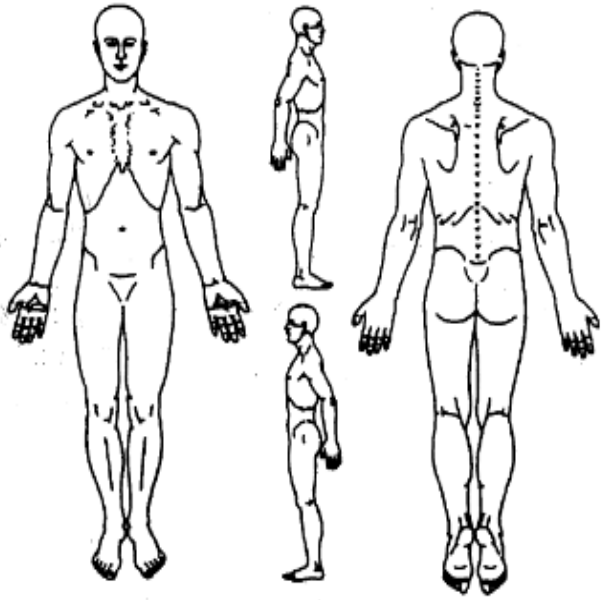
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No Date Due _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____

What type of regular exercise do you perform?

None Some Moderate Strenuous

Height ____ft____in

Weight _____lbs

In Office Use

BP _____/_____

BPM _____

For each of the conditions listed below, place a check in the Past Column if you have had the condition in the past. If you presently have the condition place a check in the present column.

Past	Present		Past	Present		Past	Present	
		Headache			**High Blood Pressure**			**Chronic Sinusitis**
		Neck Pain			**Heart Attack**			**Diabetes**
		Upper Back Pain			**Chest Pains**			**Excessive Thirst**
		Mid Back Pain			**Stroke**			**Frequent Urination**
		Low Back Pain			**Angina**			**Smoking/Use Tobacco**
		Shoulder Pain			**Kidney Stones**			**Drug/Alcohol Dependence**
		Elbow/Upper Arm Pain			**Kidney Disorders**			**Allergies**
		Wrist Pain			**Bladder Infection**			**Depression**
		Hand Pain			**Painful Urination**			**Systemic lupus**
		Hip/Upper Leg Pain			**Loss of Bladder Control**			**Epilepsy**
		Knee/Lower Leg Pain			**Prostate Problems**			**Dermatitis/Eczema/ Rash**
		Ankle/Foot Pain			**Abnormal Weight Gain/Loss**			**HIV/Aids**
		Jaw Pain			**Loss of Appetite**			***Females Only***
		Joint Swelling/Stiffness			**Abdominal Pain**			**Birth Control Pills**
		Arthritis			**Ulcer**			**Hormonal Replacement**
		Rheumatoid Arthritis			**Hepatitis**			**Pregnancy**
		General Fatigue			**Liver/gall Bladder Disorder**			***Other***
		Muscular in-coordination			**Cancer**			
		Visual Disturbances			**Tumor**			
		Dizziness			**Asthma**			

Indicate if an immediate family member has had any of the following:

	Relation(s)
Rheumatoid Arthritis	
Heart Problems	
Diabetes	
Cancer	
Lupus	
Scoliosis	
Migraine/Headaches	
High Blood Pressure	
Neck Pain	
Back Pain	

List all prescriptions, over-the-counter medications, and nutritional supplements you are taking:

_____

_____

List all of the surgical procedures you have had and times you have been hospitalized:

_____

_____

Please read thoroughly, *INITIAL* at each section

Cancellation policy

_____ 24 hour notice is required if you have to cancel your appointment, otherwise the full treatment price will be charged. Thank You.

Information about Possible Risk of Treatment

_____ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of Chiropractic, Medical Doctors, Massage Therapists and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health care procedure, complications may arise during treatment. These complications include soreness, muscle or ligament sprain/strain, dislocation, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Usual and Customary Rates

_____Peterson Health Clinic LLC is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Assignment of Insurance Proceeds

_____If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, diagnostic testing, or any other reimbursable treatment or evaluations you receive to our clinic directly.
In exchange for services and supplies rendered, I do assign to Peterson Health Clinic LLC., any insurance proceeds, including accident and health insurance benefits and bodily injury claim awards up to the amount of any unpaid balance with interest as allowed by law.

Authorization to Treat a Minor (under the age of 18)

I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Peterson Health Clinic LLC.

_____

Signature of Patient or Responsible Party **Date** **Relationship to Patient**

Records Release Authorization

_____You, Peterson Health Clinic LLC. are authorized to release any information contained in my file to any insurance company, attorney, adjuster or member of my office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties, should phone contact be required for the purpose of obtaining payment for charges outstanding.

Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation**.**

Patients Without Insurance

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

Group or Individual Insurance

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"On The Job" Injury (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

Personal Injury or Automobile Accidents

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Insurance Forms/Payment

Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Peterson Health Clinic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Peterson Health Clinic and my insurance company. I request that Peterson Health Clinic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Peterson Health Clinic that fees will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) **Date**

Notice of Privacy Practices

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Peterson Health Clinic LLC., we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If we are ordered by the courts or other professional agency.

Any use or disclosure of your protected health information, other as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care or other treatment from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like this information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

_____

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party:

_____ _____ _____

Personal Representative (Printed) Personal Representative Signature Date Description of Authority