AZ PREMIER
CHIROPRACTIC • REHAB • MEDICAL

This Form needs to be completely filled out in accordance to the federal HIPAA. Please print legibly. Thank You!

Patient Information

Last Name	First Name	MI	Date of Birth	SSN	
Mailing Address			City	State	Zip Code
Appointment reminders are sent by email, text or by voicemail.	Email Address:		Cell Phone:	Home Phone:	

***Release of Information**
List names of those who may receive your Protected Health Information: (medical records, image reports, etc.)

Emergency Contact / Relation

Employer Name / Occupation: _____

Spouse or Patient's Guardian Name: _____

Spouse Employer: _____

Do you give consent for your minor to be treated in your absence? _____ YES _____ NO

* ***Whom may we thank for referring you? Doctor, Attorney or Patient*** : _____

If not referred, you found us from: Google - Insurance Company - Other: _____

Primary Insurance

Insurance Name	ID#	Group#	Insurance Phone Number(s)	
Policy Holder Name	Date of Birth	SSN	• Male • Female	Relationship to Patient
Policy Holders Address (if different then above)		Employer (if insurance is through work)		

Secondary Insurance

Insurance Name	ID#	Group#	Insurance Phone Number(s)	
Policy Holder Full Name	Date of Birth	SSN	• Male • Female	Relationship to Patient
Policy Holder Address (if different then above)		Employer (if insurance is through work)		

By signing this form, I confirm that:

- All information provided is true and correct.
- It is my responsibility to know my insurance benefits.
- Should there be a denial in claims, I am liable to pay for services rendered, including fees for attorney and collections.
- I must pay the penalty charge: **$20.00 no-show fee, $20.00 same-day cancellation fee** and other applicable charges.
- I consent to the use and disclosure of my Protected Health Information unless otherwise noted.
- I know my right to review AZ Premier Chiropractic and Rehab Notice of Privacy Policy: If need be, I will submit my repeal or restrictions in written form.
- I received a copy of AZ Premier Chiropractic and Rehab Policies and Agreements Form, which outlines my rights and responsibilities as a patient.

Responsible Party Information

Name (if other than patient)	Relationship to Patient	Date of Birth
Signature	Today's Date	

FOR OFFICIAL USE ONLY	Accepted By:	Checked By:	Account ID

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Medical Information

Name: _____

Reason for visit today (check all that apply)

___Auto Accident ___Neck Pain ___Low Back Pain ___ Mid back or Rib Pain ___Shoulder Pain ___Knee Pain ___Plantar Fasciitis

___Headaches Other:_____

Which describes you better:

____ I want a plan that I can commit to, to resolve the problem ____ I want a quick fix and want to come in when I feel it is necessary

Past Medical History

Have you <u>ever had</u> the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO YES	Anemia	NO YES	Back Trouble	NO YES
Hepatitis	NO YES	Mumps	NO YES	Bladder Infection	NO YES
High Blood Pressure	NO YES	Ulcer	NO YES	Chicken Pox	NO YES
Epilepsy	NO YES	Low Blood Pressure	NO YES	Kidney Disease	NO YES
Whooping Cough	NO YES	Migraine Headaches	NO YES	Hemorrhoids	NO YES
Thyroid Disease	NO YES	Scarlet Fever	NO YES	Tuberculosis	NO YES
Bleeding Tendency	NO YES	Diphtheria	NO YES	Diabetes	NO YES
Asthma	NO YES	Small Pox	NO YES	Cancer	NO YES
Hives of Eczema	NO YES	Pneumonia	NO YES	Polio	NO YES
AIDS & HIV	NO YES	Rheumatic Fever	NO YES	Glaucoma	NO YES
Infectious Mono	NO YES	Arthritis	NO YES	Hernia	NO YES
Bronchitis	NO YES	Venereal Disease	NO YES	Blood or Plasma	NO YES
Mitral Valve Prolapses	NO YES	Transfusion	NO YES	Stroke	NO YES

Family History

Mother's Age: _____ If deceased, age and cause of death: _____

Father's Age: _____ If deceased, age and cause of death: _____

Indicate which family member, has the following:

(F)Father (M)Mother (S)Sister (B)Brother (GM)Grandmother (GF)Grandfather

___Stroke ___Diabetes ___High Cholesterol ___Rheumatoid Arthritis ___Cancer ___Alcoholism ___ Heart Attack

___High Blood Pressure ___HIV

Social History

Type of work: _____ ___Stressful ___Hazardous ___Heavy Lifting
Exercise: YES / NO #_____times per week
Alcohol: YES / NO #_____drinks per day *If you used to, when did you quit? _____
*Do you smoke? YES / NO Did you ever? YES / NO How Many Daily?: _____
When did you quit? _____ Are you: ____left handed or ____right handed?

Current Medication **_(List name, dosage and frequency)_**

CONSENT FORM

I hereby request and consent to the performance of medical care and all the things involved in complete family medicine, chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures on me (or on the patient named below, for whom I am legally responsible) by the medical and/or chiropractic team at AZ Premier Chiropractic and Rehab who now or in the future work at the clinic or office listed below.
I have had an opportunity to discuss with the medical doctor or doctor of chiropractic named below the nature and purpose of treatment, chiropractic adjustments and other procedures. I understand that results are not guaranteed.
I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:
Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.
Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

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

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay AZ Premier Chiropractic and Rehab 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. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to AZ Premier Chiropractic and Rehab for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing AZ Premier Chiropractic and Rehab 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 AZ Premier Chiropractic and Rehab all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/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 Personal Representative, ERISA Representative, and 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 and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either AZ Premier Chiropractic and Rehab, myself, and/or my family members as a result of services rendered by AZ Premier Chiropractic and Rehab, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that AZ Premier Chiropractic and Rehab can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by* AZ Premier Chiropractic and Rehab. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information" (PHI)) by AZ Premier Chiropractic and Rehab in order to carry out treatment, payment, or health care operations. The Patient should review AZ Premier Chiropractic and Rehabs Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

AZ Premier Chiropractic and Rehab reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If AZ Premier Chiropractic and Rehab does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice requesting a copy.

Patient retains the right to request that AZ Premier Chiropractic and Rehab further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. AZ Premier Chiropractic and Rehab is not required to agree to such requested restrictions; however, if AZ Premier Chiropractic and Rehab does agree to Patient's requested restriction(s), such restrictions are then binding on AZ Premier Chiropractic and Rehab.

I understand that, and consent to, the following appointment reminders that will be used by AZ Premier Chiropractic and Rehab, in writing, such as a postcard, a telephone call at designated number and leaving a message on a voice mail or with the person answering the phone, by text, or by email.

This consent is valid for seven years. At all times, patient retains the right to revoke this consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that AZ Premier Chiropractic and Rehab has already taken action in reliance on the Consent.

AZ Premier Chiropractic and Rehab may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that AZ Premier Chiropractic and Rehab is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, AZ Premier Chiropractic and Rehab has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that AZ Premier Chiropractic and Rehab is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Print Name of Patient: _____

Relationship to Patient: _____

Signature: _____

Date: _____