Bene Vida
HEALTH + WELLNESS CENTER

Patient Information

Date_____

Patient Name _____

Address _____

City_____ State_____ Zip Code_____

Gender M F Birth date _____ Age_____ SS# _____

Employer/School_____Occupation_____

Relationship Status: Married _____ Single _____ Divorced _____

Domestic Partnership _____ Widowed _____ Other _____

Primary Care Physician _____

May we consult your doctor regarding your care in our office? Y N

E-mail _____

Contacts

Home Phone (____)_____

Cell Phone (____)_____

Work Phone (____)_____

Best number to reach you during business hours:

___Home ___Cell ___Work

Who may we thank for referring you?

_____

__Internet __Yellow Pages __Walk-in __Newspaper

In Case of Emergency, contact:

Name_____

Relationship_____

Phone number(s)_____

Patient Condition/Accident Information

Reason for visit _____

When did your symptoms appear? _____

Is this condition due to an accident? Y N Date of accident _____

What type of accident? Auto _____ Work _____ Home _____ Other _____

Is this condition getting progressively worse? Y_____ N_____ Unknown_____

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting ___

Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it radiate? Y N If yes, where? _____

Does it interfere with your: Work _____ Sleep _____ Daily Routine _____ Recreation _____

Activities or movements that are painful to perform:

Sitting _____ Standing _____ Walking _____ Bending _____ Lying Down _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient _____

Insurance company _____

Group # _____

Is patient covered by additional insurance? Y N

Subscriber's name _____

Birth date _____

Relationship to patient _____

Insurance company_____

Group # _____

Assignment and Release:

I certify that I, and/or my dependents(s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, guardian, or personal representative _____

Printed name: _____

Date: _____

Relationship: _____

Medical History

What treatment have you already received for your condition?

Medications ____ Surgery ____ Physical Therapy ____ Chiropractic ____ Acupuncture ____ None ____ Other _____

Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-ray _____ Chest X-ray _____ Blood Test _____

MRI, CT Scan, Bone Scan _____

Please CIRCLE to indicate if you currently HAVE & <u>underline</u> if you have HAD any of the following:

AIDS/HIV	Chemical Dependency	Herpes	Joint Problems	Rheumatoid Arthritis
Alcoholism	Diabetes	High Cholesterol	Headaches	Stroke
Anemia	Fibromyalgia	Kidney Disease	Sciatica	Hyperthyroidism
Appendicitis	Fractures	Liver Disease	Osteoporosis	Hypothyroidism
Arthritis	Heart Disease	Migraines	Pacemaker	Skin Condition
Asthma	Hepatitis	Mononucleosis	Pinched Nerve	Circulatory Disorder
Bleeding Disorders	Hernia	Multiple Sclerosis	Prostate Problem	Tumors, Growths
Cancer	Herniated Disk	Numb hands/feet	Prosthesis	Other _____

Please CIRCLE to indicate if you currently HAVE & <u>underline</u> if you have HAD any of the following:

Allergy Shots	Chicken Pox	Gout	Polio	Tuberculosis
Anorexia	Emphysema	Measles	Psychiatric Care	Typhoid Fever
Breast Lump	Epilepsy	Miscarriage	Rheumatic Fever	Ulcers
Bronchitis	Glaucoma	Mumps	Scarlet Fever	Vaginal Infections
Bulimia	Goiter	Parkinson's Disease	Suicide Attempt	Venereal Disease
Cataracts	Gonorrhea	Pneumonia	Tonsillitis	Whooping Cough
Alzheimer's	High Blood Pressure	Cystic Fibrosis	Emotional Disorder	Hemophilia
Crohn's Disease	Irritable Bowel (IBS)	Lupus (SLE)	Seizures	Ulcerative Colitis
Other _____	Other_____			

Medications/Supplements

MEDICATION	DOSAGE	REASON	HOW LONG	PRESCRIBED BY	LAST EVALUATION

Allergies: _____

Health History

Please indicate your use/intake of the following:

			Amount (per day)
Water intake	Y	N	_____
Sodas	Y	N	_____
Recreational Drugs	Y	N	_____
Alcohol	Y	N	_____
Coffee/Black Tea	Y	N	_____
Tobacco	Y	N	_____

Injuries/Surgeries you have had:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Car Accidents	_____	_____

Exercise: ____ None ____ 1X/MONTH ____ 1X/WK ____ 2-3X/WK ____ 4X +/WK

Work Activity: ____ Sitting ____ Standing ____ Light Labor ____ Heavy Labor ____ Other _____

Stress Level: ____ Low ____ Moderate ____ High Sources of Stress _____

What activities, if any, do you participate in to reduce your stress levels? _____

Are you pregnant? Y N Due Date_____

Have you ever had a lapse of memory? Y N When? _____

Were you ever knocked unconscious? Y N When? _____

How many hours per day do you use a computer? _____

How many hours of quality sleep do you get each night? _____

Symptom Survey

Please CIRCLE to indicate if you currently HAVE & <u>underline</u> if you have HAD any of the following:

If current, indicate how often you experience that symptom.

Lack of appetite
Excessive appetite
Loose stool
Blood in stools
Diarrhea
Indigestion
Vomiting/Nausea
Belching/Burping
Heartburn/Acid reflux
Bloating
Food retained in stomach
Depression
Fatigue
Obsessive tendencies
Insomnia
Heart palpitations
Cold hands and feet
Nightmares
Anxiety
Mentally restless

Excessive talking
Inappropriate laughter
Chest pain
Abdominal pain
Sciatic pain
Coughing
Shortness of breath
Poor sense of smell
Sinus/nasal problems
Tightness in the chest
Skin rashes
Dry skin
Severe acne
Pain or coldness in genitals
Hemorrhoids
Black/tarry stool
Diverticulitis
Gallstones
Difficulty digesting oily food
Light colored stool

Eye problems
Jaundice
Easily angered/irritated
Difficulty making decisions
Soft or brittle nails
Muscle spasms/twitching
Dizziness/vertigo
Low back pain
Knee problems
Poor hearing
Ringing in ears
Hair loss
Kidney stones
Urinary difficulty
Edema
Other _____
Other _____
Other _____

FINANCIAL RESPONSIBILITY

This office is committed to providing you with the best possible medical care, and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

- WE ACCEPT CASH, LOCAL CHECKS, CREDIT CARDS (VISA, MASTERCARD, DISCOVER, AMEX), AND CARECREDIT
- PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

INSURANCE IS A CONTRACT BETWEEN <u>YOU</u> AND <u>YOUR INSURANCE COMPANY</u>

We do not accept assignment for Medicare, however, we will charge our cash prices and electronically submit an insurance claim for you – as a courtesy to you. During your chiropractic visit, you will receive extra care in addition to your adjustment. We perform several procedure codes; however Medicare covers the adjustment code ONLY. Typically you will be mailed a partial refund, between $24-$26 for your adjustment along with a letter explaining your benefits.

We accept assignment for Workers' Compensation and most Medical Insurances. We will electronically bill your insurance company for payment, but we are not a party to your insurance contract. Again, we will bill your insurance company as a courtesy to you. You will still be responsible for deductibles, and any and all services, not covered by your insurance company.

Pre-Payments: Patient is entitled to a reimbursement for services not rendered, however all used sessions will be billed at the non-discounted rate and refunded remaining balance.

MISSED APPOINTMENTS

As a courtesy to your fellow patients and to our staff, we require at least 24 hours notice of cancellation of any appointment. Unless your appointment is cancelled at least 24 hours in advance we will charge you at the rate of a normal office visit (insurance does not cover missed appointments.) Please help us serve you better by keeping your scheduled appointments.

PATIENT LIENS

I fully understand that I am directly responsible to Bene Vida Health + Wellness Center for all medical bills submitted by them for services rendered to me. Further, this agreement is made solely for this facility and it's practices, additional protection and in consideration of awaiting payment.

Should any of my account balances be turned over for collections, I agree that I will be responsible for all attorney fees, court costs, collection fees, certified mailing fees and interest that is accrued on my balance until paid in full at 18% per anum.

_____ _____

Signature of Patient or Responsible Party Date

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Bene Vida Health + Wellness Center, LLC Legal Duty

Bene Vida Health + Wellness Center, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USE AND DISCLOSURES OF HEALTH INFORMATION

Bene Vida Health + Wellness Center, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative actives and evaluating the quality of care that we provide. For example, Bene Vida Health + Wellness Center, LLC may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives or other health related benefits that could be of interest to you.

Bene Vida Health + Wellness Center, LLC may also use or disclose your personal health information without prior authorization, for auditing purposes, for research studies and for emergencies. We also provide information required by law.

In any other situation, Bene Vida Health + Wellness Center, LLC policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Bene Vida Health + Wellness Center, LLC many change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purpose except when specifically authorized by you, when required by law or in emergency circumstances. Bene Vida Health + Wellness Center, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Bene Vida Health + Wellness Center, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed on the notice. You may also send a written complaint to the US department of Health and Human Services.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Bene Vida Health + Wellness Center, LLC Information Practices. I understand that Bene Vida Health + Wellness Center, LLC may use or disclose my personal health information to any professionals in the office for the purposes of carrying out treatment, evaluating the quality of services provided, obtaining payment or completing any other administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Bene Vida Health + Wellness Center, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use of disclosure of my personal health information for purposes as noted in Notice of Info Bene Vida Health + Wellness Center, LLC information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature Date

Bene VIDa
HEALTH + WELLNESS CENTER

CHIROPRACTIC – Informed Consent

The nature of the chiropractic manipulation: I will use my hands or instrument to move joints of your body. This may result in an audible "pop" or "click".

The material risk inherent in an adjustment: As with any health care procedure, there are certain complications that may arise during a chiropractic manipulation. This may include strains, dislocations, fractures, disc injuries, and strokes. This list in not all conclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher. We employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatment recommended: Manipulations, cervical rehabilitation, cervical traction, lumbar traction, lumbar rehabilitation, manual therapy, electrical modalities, physical modalities, ice therapy, and heat therapy.

Other treatment options for your condition may include: Medical care with prescription drugs, self-management with over-the-counter medication, rest and/or surgery. There is material risk inherent in each of these options, including but not limited to, addiction to medications, side effects of medication, improper self-dosage, and surgical risk, including complications from the procedure and the anesthesia.

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighted the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name: _____ Date: _____

Patient Signature: _____