PATIENT INFORMATION **Date _____/_____/_____**

Patient Name (last, first)_____ Preferred Name _____

Home Phone (_____)_____ Work Phone # (_____)_____ Cell # (_____)_____

Social Security #_____ E-Mail Address _____

Address_____ City_____ State_____ Zip Code_____

Date of Birth _____/_____/_____ Age_____ Sex: M F Patient Employer _____

Work Address_____ City_____ State_____ Zip Code_____

Occupation / Job Description _____

Marital Status (circle one): Single Married Widowed Divorced Separated Domestic partner _____

Note: *(Only fill out this section if the patient is different from the insured)* Insured Name:_____

Address_____ City_____ State_____ Zip Code_____

Social Security #_____ Home Phone # (_____)_____ Date of Birth _____/_____/_____

Insured Employer _____ Work Phone # (_____)_____

Work Address_____ City_____ State_____ Zip Code_____

Review of Systems: *Please write in a number:* 1. PRESENTLY HAVE 2. PREVIOUSLY HAD 3. RELATED TO ACCIDENT

General

___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors
___Anxiety / Depression

Eyes, Ears, Nose, Throat

___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Near sighted
___Hoarseness
___Nasal obstruction

Musculoskeletal

___Arthritis
___Bursitis
___Foot trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain

Pain or numbness in:

___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Ankles
___ Feet
___ Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

Genito-urinary

___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

Cardiovascular

___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

Respiratory

___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

Gastrointestinal

___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Heartburn / reflux
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

DOCTOR ONLY: _____

_____

_____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

headache **neck** **low back**

no pain _____|_____|_____|_____ **worst possible pain**

##

1. What is your pain RIGHT NOW?

no pain _____ **worst possible pain**

2. What is your TYPICAL or AVERAGE pain?

no pain _____ **worst possible pain**

3. What is your pain level AT ITS BEST?

no pain _____ **worst possible pain**

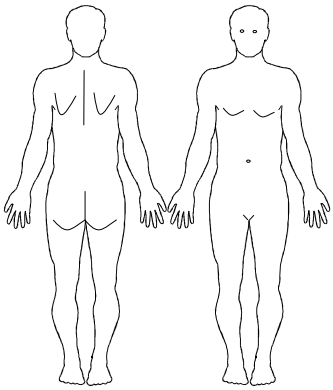
What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST?

no pain _____ **worst possible pain**

What percentage of your awake hours is your pain at its worst? _____%

Mark the diagram as follows:
A - Ache
B - Burning
N - Numbness
P - Pins & Needles
S - Stabbing
O - Other - Describe



NAME _____ **AGE**_____ **DATE**_____ **SCORE**_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

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www.chiroevidence.com

Pro-Motion Chiropractic and Rehabilitation, 4030 Lake Creek Dr. N., Wilson, WY
Telephone: 307.699.3170

FINANCIAL POLICY FOR PATIENTS WITH HEALTH INSURANCE

Patient Name: _____ **Social Security #:** _____
Last Legal First Middle

Name of Insured:_____ Social Security#:_____
(if different from patient) Last Legal First Middle

Pro-Motion Chiropractic and Rehabilitation is "In-Network" with Blue Cross/Blue Shield PPO and Private Health Care System (PHCS) Plans only. All other insurance plans are considered "Out-of-Network."

For "In-Network" Insurance Plans. All co-payments, co-insurance, deductibles, and non-covered services are due at the time of service. We will submit a claim one time on the patient's behalf. You are responsible for payments of all services your insurance company may deny or fail to pay.

For "Out-of-Network" Insurance Plans. Payments for all services are due in full at the time services are provided. We will submit a claim one time on the patient's behalf with any reimbursements to go directly to the patient.

Pro-Motion Chiropractic and Rehabilitation is under no obligation to pursue reimbursement on the patient's behalf other than the one-time submission of the claim.

Primary Insurance Company or Health Care Plan Name: _____ **Effective Date:**_____
ID#: _____ **Policy/Group#:** _____
Secondary Insurance Company or Health Care Plan Name: _____ Effective Date: _____
ID#: _____ Policy/Group#: _____

→FOR "IN-NETWORK" INSURANCE PLANS ONLY: As the recipient of services from Pro-Motion Chiropractic and Rehabilitation, you are ultimately responsible for payment for all services provided. In order for our office to bull your insurance plan, you must provide your credit card information below. Your credit card will be kept on file. Our office will submit a claim one (1) time to your above listed Health Insurance Provider. If payment from you In-Network Health Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, a courtesy letter will be written to your attention notifying you that your bill has not been paid. It is thereafter *your responsibility* to ensure that your health insurance pays your bill for services. If payment is not received in full within sixty (60) days, by providing your card below and receiving provided services, you are authorizing Pro-Motion Chiropractic and Rehabilitation to charge your provided credit card for any unpaid bills of claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to the patient.

CREDIT CARD #: _____ **EXPIRATION DATE:**_____
CARDHOLDER SIGNATURE: _____ **DATE:**_____

→ Appointments may be cancelled if notice has been provided at least 24 hours in advance. In the event of a missed appointment not cancelled at least 24 hours in advance, a fee of $75.00 applies and will be charged to the credit card on file.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary t process any insurance claims. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits received form the above doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. This assignment will remain in effect until revoked by e in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and full understand this agreement.

SINGATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____
SIGNATURE OF INSURED (if different from patient/guardian)/GUARDIAN: _____ **DATE:** _____

ASSIGNMENT (of benefits to doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or health care benefits coverage with the above captioned Health Insurance Provider, and hereby assign and convey directly to Pro-Motion Chiropractic and Rehabilitation all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

SINGATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____
SIGNATURE OF INSURED (if different from patient/guardian)/GUARDIAN: _____ **DATE:** _____

PLEASE PROVIDE US WITH THE NECESSARY INFORMATION TO SUBMIT A REPORT:

Primary care Dr.: _____ **Tel.:** _____ **Address:**_____

This is Page 5 of 5 of the HIPAA Privacy Policy (there are 4 prior pages not shown here in the intake form section). If you are interested in reading the entire document, or would like a copy of it, please ask on the day of your first appointment. Care will not begin without the signing of this final page of the policy. We will be happy to make you a full copy of the policy.

Same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

1. Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
2. Complain to the Practice, or the the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, D.C. 20201. Or you may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/regmail.html. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
3. To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Jeremiah Handschin, at 307-699-3170 or via email at www.promochiro.com.

PRACTICE REQUIREMENTS

The Practice:

1. Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Practice's legal duties and privacy practices with respect to your PHI.
2. Is required to abide by the terms of this Privacy Notice.
3. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all or your PHI that it maintains.
4. Will not retaliate against you for making a complaint.
5. Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.
6. Will post this Privacy Notice on the Practice's website, if the Practice maintains a web site.
7. Will provide a paper copy of this Privacy Notice to you. If the office feels it is appropriate and privacy secure we will provide an email copy of this to the patient.

EFFECTIVE DATE

This Notice is effective as of November 1st, 2008

ACKNOWLDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice that has an effective date of _____, 20____.

_____ _____

Name of Individual (Printed) Signature of Individual

Date Signed _____/_____/_____

ProMotion
chiropractic & rehabilitation

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care.
The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

ProMotion
chiropractic & rehabilitation

I have read or had read to me this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction* ***prior to my signing this informed consent document***. I have made my decision voluntarily and freely.

_____ _____
Signature of Patient or Guardian Date

_____
Signature of Witness

Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

[ ] Of legal age
[ ] Consent given through Guardian
[ ] Oriented x3
[ ] Appears unimpaired
[ ] Fluent in English
[ ] Assisted by a translator or interpreter

_____, D.C. _____
Signature of Chiropractor Date

_____
Signature of Translator or Interpreter,
If applicable