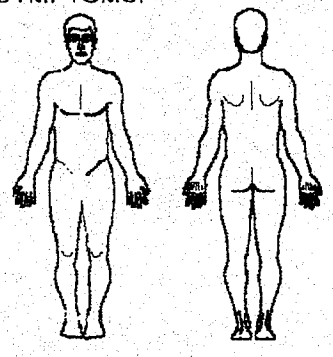
INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_____
How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

email: _____

Santelli Chiropractic Clinic

Financial Policy:

Definitions: "I", "me" and "my" mean the patient. "Clinic", means Santelli Chiropractic Clinic and its employees. I am signing this agreement to obtain services. A photo copy of this form shall be as effective and valid as the original.

We are committed to providing you with quality care. If you have health insurance, we want to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Our facility participates in a number of PPO networks. It is your responsibility to verify that the doctor/facility you are seeing is "in network". Please verify this by calling the "800" telephone number on your group insurance card or check with your employer on how to obtain this information.

If you belong to an insurance company that requires a referral from your primary care physician, please bring the referral with you at the time of your appointment. We must have a referral authorization before seeing you. If a referral is not obtained and your insurance does not pay, you are responsible for the unpaid balance.

Copayments are collected on each visit. If you are not insured by one of the participating PPO insurance companies, payment will be collected according to your plan's out-of-network benefits. If you carry no medical coverage, payment in full is required at the time of your visit unless prior arrangements have been made. We accept cash, checks, MasterCard, Visa, Discover and Care Credit.

Medicare: We accept Medicare assignment and will bill Medicare for you. As a Medicare beneficiary, you are required by Medicare to make a co-insurance payment for your physician's professional services. Your co-insurance payment amount depends on the services you receive from your physician. If you have any supplemental insurance, please provide this information prior to your appointment.

I irrevocably assign and transfer to the Clinic all Medicare and/or insurance benefits covering services for payment of services rendered.

If treatment is sought due to a motor vehicle accident or other personal injury, you will be responsible for your bill. i.e. Office visits, x-rays, any tests, therapies or procedures. We will work with Personal Injury Protection (PIP) insurance.

If you are seeking treatment for an injury that occurred on a school campus, you must bring a claim form completed by the appropriate school official. This claim form should include details of the accident and the name and address of the schools insurance company.

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. There will be a $30 charge for all returned checks. We do not accept postdated checks.

I have read and completely understand the financial policy of Santelli Chiropractic Clinic.

Signature of Patient or Responsible Party:_____ Date:_____

Santelli Chiropractic Clinic
890 W. Corsicana St., Suite 5
Athens, TX 75751 ph. 903-677-1936

Patient Informed Consent

Definitions: "I," "me," and "my" mean the patient. "Clinic," means Santelli Chiropractic Clinic and its employees. I am signing this agreement to obtain services.

If any part of this agreement is invalid, it will not affect the validity of the remainder of this agreement. Any invalid part will be deemed reformed to comply with the law. A photo copy of this form shall be as effective and valid as the original.

Please initial each statement:

_____**Authorization for Care:** I grant permission for the clinic to render such care that Dr. Santelli may deem necessary in my diagnosis and treatment. I understand that such care may include chiropractic treatment, diagnostic test, therapies and supplements. Although very rare there are complications which may arise during treatment. These complications include but are not limited to: fracture, muscle strain, costovertebral strain/fracture and cervical vertebral accident.

_____ **Continuity of Care:** While decisions about every patients care remains the shared responsibility of the patient and the chiropractor, Dr. Santelli believes that patient needs can best be met by referring to specialists when the specialty is available and deemed necessary.

_____ **Authorization for Release and/or Acquisition** of Information: I hereby authorize Santelli Chiropractic Clinic to release and/or acquire necessary protected health information from third parties, including but not limited to other physicians for continuing professional care, any insurance company or third party payor for the purpose of processing a claim, or otherwise as allowed by law. I release the Clinic from any liability for the release and/or acquisition of this information, and I understand this release specifically includes any and all blood and related tests, including those for HIV and other diseases.

_____ HIPAA **Notice** of Privacy **Practices:** Santelli Chiropractic Clinic is required by applicable federal and state law to maintain the privacy of your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present of future physical or mental health condition and related health care services. We are required to give you notice about our privacy practices and your rights concerning your PHI. By initialing this space, you acknowledge that you have been given or offered the "Notice of Privacy Practices" of this Clinic.

Signature of Patient or Representative: _____Date:_____

Relationship to Patient if patient is unable to sign or is a minor: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviews this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Furthermore, by my specific initials, I authorize my physician and his/her staff, to contact me by the designated means noted below.

_____Home Phone

_____Home Answering Machine/Voice Mail

_____Office/Work Place, Voice Mail

_____Cell Phone/Voice Mail

_____Reminder Cards by Mail

_____Fax # ( )_____Location:_____

Additionally, by my initials I authorize my physician and his/her staff, to communicate information regarding appointments, medical results and billing issues to:

_____Spouse_____

_____Others_____

This authorization shall remain in force until revoked in writing, Attention of Privacy Officer

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority