CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic therapy can help you. If we do not believe your condition may respond satisfactorily, we will not accept your case. THANK YOU.

NAME_____ DATE_____ SS#_____ HOME #(____)_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____ WORK #(____)_____

DATE OF BIRTH_____ AGE_____ M____ F____ MARRIED: Y / N CELL #(____)_____

OCCUPATION_____ EMPLOYER _____EMAIL:_____

PERSON RESPONSIBLE FOR ACCOUNT_____ SPOUSE_____ REFERRED BY_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O-OCCASIONAL
F-FREQUENT
C-CONSTANT

O F C
MUSCLE & JOINT
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Low Back Pain or Stiffness
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Painful Tailbone
☐ ☐ ☐ Upper Back Pain
☐ ☐ ☐ Neck Pain or Stiffness
☐ ☐ ☐ Poor Posture
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen Joints

O F C
MUSCLE & JOINT
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Upper Arm
☐ ☐ ☐ Forearms
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
OTHER
☐ ☐ ☐ Losing Weight
☐ ☐ ☐ High Cholesterol
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Painful Menstruation (Women Only)
☐ Yes ☐ No Are you pregnant?

O F C
GENERAL
☐ ☐ ☐ Allergy
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fever
☐ ☐ ☐ Loss of Sleep
☐ ☐ ☐ Constipation
☐ ☐ ☐ Asthma
☐ ☐ ☐ Earache
☐ ☐ ☐ Sinus Infection
☐ ☐ ☐ Bed Wetting
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Headaches

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD

☐ Alcoholism ☐ Cancer ☐ Epilepsy ☐ Heart Disease ☐ Stroke
☐ Appendicitis ☐ Diabetes ☐ Gout ☐ Miscarriage ☐ HIV/Aids

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus, information about your family members will give us a better idea of your total health picture.

Family Member (mother, grandfather etc.)	**Cancer**	**Stroke**	**Heart Dis.**	**Diabetes**	**Spinal Conditions**

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):
NAME_____ RELATION_____ PHONE_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

Have you ever had previous chiropractic care? ☐ Yes ☐ No If yes, date of last care and name of doctor_____
Do you have Health or Accident Insurance? ☐ Yes ☐ No If yes, with what company?_____

CHIEF COMPLAINT

What is your major complaint?_____ When did this begin?_____
Second complaint_____ When did this begin?_____
Third complaint_____ When did this begin?_____
Fourth complaint_____ When did this begin?_____

Is this condition (your major complaint) getting progressively ☐ Better, ☐ Worse, ☐ Staying the same Is it: ☐ Constant ☐ Intermittent
Have you had this or similar conditions in the past? ☐ Yes ☐ No When?_____ Describe_____
What improves your condition? ☐Rest ☐Ice ☐Heat ☐Medications ☐Lying down ☐Standing ☐Sitting ☐Walking ☐Other_____
What aggravates your condition? ☐Lying ☐Standing ☐Sitting ☐Walking ☐Running ☐Exercising ☐Coughing ☐Other_____
How would you describe the pain? ☐Sharp ☐Stabbing ☐Dull ☐Achy ☐Burning ☐Throbbing ☐Tingling ☐Numbing ☐Other_____
Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other_____
How long has it been since you felt really good?_____

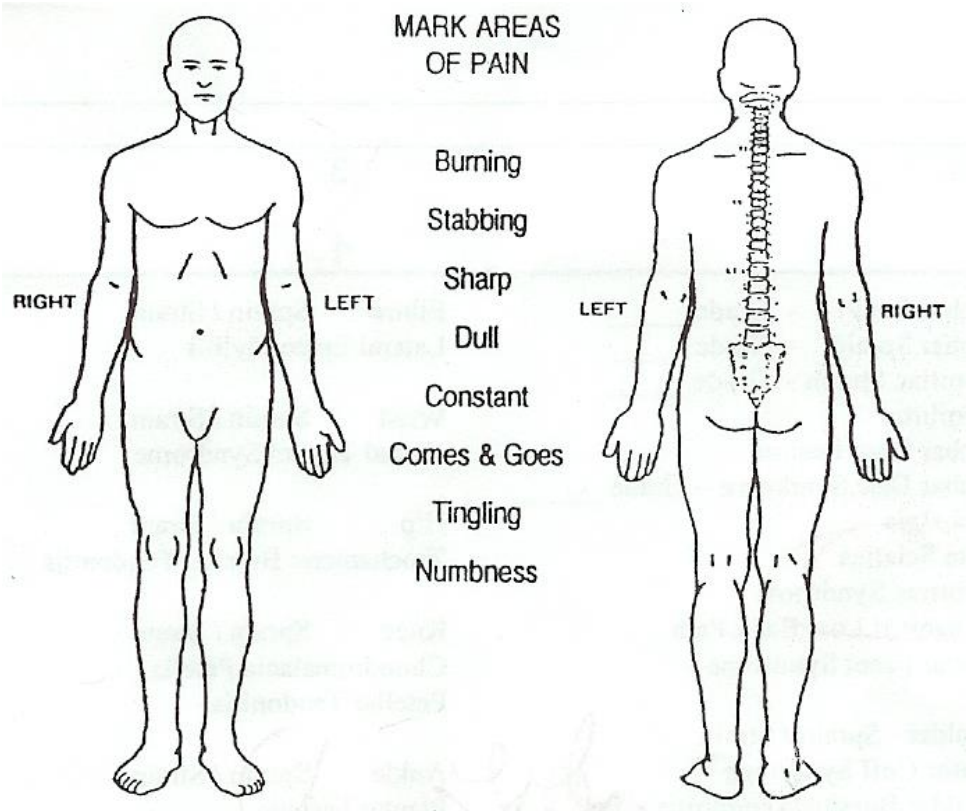
List previous diagnoses and treatments you have had for this/these conditions_____

_____
What caused your pain/condition to develop?_____
List surgical operations and years:_____

_____
Drugs you now take: ☐ Pain Killers ☐ Anti-inflammatory ☐ Muscle Relaxants ☐ Blood Pressure ☐ Cholesterol ☐ Birth Control
☐Anti-depressants Other:_____
Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe:_____
Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When?_____
Have others in your family had such disorders? ☐ Yes ☐ No When?_____

NAME OF YOUR MEDICAL DOCTOR_____ PHONE NUMBER_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

MAY WE SEND A REPORT OF YOUR TREATMENT TO YOUR DOCTORS and/or THERAPISTS? ☐ Yes ☐ No



Date:_____ **Signature:**_____
(Parent or legal guardian if a minor)

Thank you for choosing our office to help you reach your elite level of health. We will do whatever it takes to provide the best chiropractic and rehabilitative services available-in a loving, caring and healing environment. Our goal is to improve your life by decreasing your pain, increasing your function and improving your overall quality of life.

FINANCIAL DISCLAIMER

We strive to make care affordable for all our patients, whether those patients are self pay or using insurance.

If you have insurance, we will gladly file your insurance on your behalf. Insurance is not a substitute for payment but considered a method of reimbursing the patient for fees received from treatment by the doctor. Our doctors will recommend treatment based upon the patient's needs, not based on insurance coverage or benefits.

As a courtesy we will call to verify your insurance coverage. Insurance verification is not a guarantee of payment, but a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Our office will willingly provide any necessary documentation the insurance company may request to resolve any questions that may arise regarding your claim.

A copy of your insurance card is required at the time of the initial visit or any time there is a change to your insurance coverage. The card is descriptive and indicates whether an authorization is needed. If a card is not presented and your claim is denied for "no authorization" or any other reason, you will be responsible for the balance. Since many insurance plans require prior authorization before receiving care and have a time limit in which to receive the authorization, we will not bill the insurance company or reimburse you for services rendered if your insurance card was not received during your initial visit.

Insurance co-pays and deductibles are due at the time of service.

Our office offers a discount to self pay patients when they pay the balance in full at the time of service. Our usual office fees apply when services are not paid in full at the time of service. Our office also offers an Auto Pay Plan to assist patients in paying for services rendered. If you choose this option, payment will conveniently be charged to your credit card or deducted from your bank account at a frequency of your choosing. Please speak to our billing department for more details regarding this program.

Our office will do all it can to accurately inform you of any balance to your account. In the event that a second account statement is sent when there is no response from the patient/responsible party, there will be a $15.00 fee charge. If you are delinquent using our Auto Pay Plan you will be charged this fee each month you miss your payment. Accounts over 30 days old without payments or response will be sent to an outside collection agency.

AGREEMENT AND AUTHORIZATION

I, the undersigned, hereby agree and consent to evaluation, treatment and any diagnostic x-rays deemed necessary to treat my condition by Elite Chiropractic doctors and/or staff.

As consideration for the provision of the treatment to which I consent, I agree I am fully responsible for all services received in this office. I agree to pay timely for all services as charges become due and owing after treatment is administered to me and I understand that payments for such are my responsibility regardless of insurance benefits, health maintenance benefits, third party liability, or the involvement of any attorney. I understand that all policies or agreements for health and accident benefits are an arrangement between the insurance company/health maintenance organization and me. I understand that it is my responsibility to research and understand my own insurance coverage including co-pays, deductibles, co-insurance, visit limitations, etc. I understand that any attempt by the chiropractic office/staff to assist in researching coverage is only done as a courtesy to me and is an estimate, which may not always be accurate. I agree to personally be responsible for and to pay to Elite Chiropractic and Performance Center L.C. promptly, all deductibles, co-pays, co-insurance, and charges for services that any insurance company/health maintenance organization or carrier may not, or for any reason, may decline to pay on my behalf. There is a $15.00 returned check fee on all returned checks, regardless of any reason.

Furthermore, I hereby authorize and agree that the office staff as a courtesy to me may assist me by preparing and submitting claims for collection of benefits and/or payment from my insurance company/health maintenance organization. I agree that all payments made by third parties on my behalf for care rendered to me by the doctors and/or staff should be made to and delivered to Elite Chiropractic and Performance Center L.C. and that any such amounts paid to this office will be credited to my account upon receipt. I authorize the release of any medical or other information to my insurance company/health maintenance organization, third-party carrier, or attorney as may be necessary to process claims for benefits or payments. I hereby assign to Elite Chiropractic all benefits and payments due for chiropractic and rehabilitative services.

If this account is assigned to an outside agency for collection, I/we agree to pay all attorney fees with or without suit, court costs, and a collection charge of 50%, which will be added to the outstanding balance of my account.

Date: _____ Signature: _____ Relationship _____
(Patient or Legal Guardian if a minor)

CONSENT TO TREATMENT OF A MINOR
(If applicable)

I, the undersigned parent/legal guardian of _____, a minor, do hereby authorize and consent to any x-ray, examination, diagnosis, recommendation, or treatment which is deemed advisable by a licensed chiropractor, or under general supervision of a chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required.

This authorization shall remain effective indefinitely, or until consent is revoked in writing and delivered to the chiropractor.

Date: _____ Signature: _____
(Parent/Legal Guardian – circle relationship)

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Rare injuries could include, but are not limited to, fractures, disc injuries, dislocations, muscle strain, or stroke. The doctor, or course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing

DATE: **SIGNATURE:**

_____ _____

(Parent or legal guardian if a minor)

HIPAA Notice of Privacy Practices

Elite Chiropractic & Performance Center
6717 S. 900 E. Suite 101
Midvale, UT 84047
(801) 432-7511

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other: We may use your name to send a thank-you to the person or organization that referred you to our office. With your consent we may use your testimonial or written statement and picture for promotional material. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

I consent to release my Protected Health Information to the individuals listed below:

_____ _____

_____ _____

_____ _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature:** _____ **Date:** _____