Advanced Spine & Health Center of Cache Valley

Dr. Thomas Fullmer
Doctor of Chiropractic

WELCOME TO ADVANCED SPINE AND HEALTH CENTER!

Patient Name: _____ Date: _____

HOW did you hear about us or WHO Referred you? (Family, friend, physician): _____

Is Today's Visit Because of a RECENT (past 3 months) Auto Accident: □ Yes □ No
(**If YES to the question above, please check with the receptionist, additional information is needed**)

Date of Birth _____/_____/_____ □ **Male** □ **Female** **Social Security #** _____-_____- _____

Marital Status: □ **Married** □ **Single** □ **Widowed** □ **Separated** □ **Divorced** □ **Other** _____

Work Status: □ **Employed** □ **Unemployed** □ **Full-Time Student** □ **Part-Time Student** □ **Other** _____

Your Occupation: _____ **Your Employer:** _____

Race: □ **American Indian/Alaska Native** □ **White** □ **Black/African American**
□ **Asian** □ **Native Hawaiian/Pacific Islander** □ **Two or More** _____

Ethnicity: □ **Hispanic or Latino** □ **Not Hispanic or Latino**

Preferred Language of Communication: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-Mail Address: _____

Preferred Method of Contact: □ **Call Home** □ **Work** □ **Cell** □ **Text Message** □ **E-Mail**

Tobacco Use: **Do you Smoke?** □ Yes □ Quit □ Never used **Do you use E-Cigarettes?** □ Yes □ No **Do you Chew Tobacco:** □ Yes □ No

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact's Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Family Physician: _____ **City:** _____ **State:** _____ **Zip:** _____

May our office inform your family physician of presenting conditions, exam findings, diagnosis, and treatment plans? □ Yes □ No

What type of care are you interested in?: □ **Pain relief only** □ **Healing of current condition** □ **Nutrition Support** □ **All Three**

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Patient Name: _____ Date: _____

What is the reason for your visit today? _____

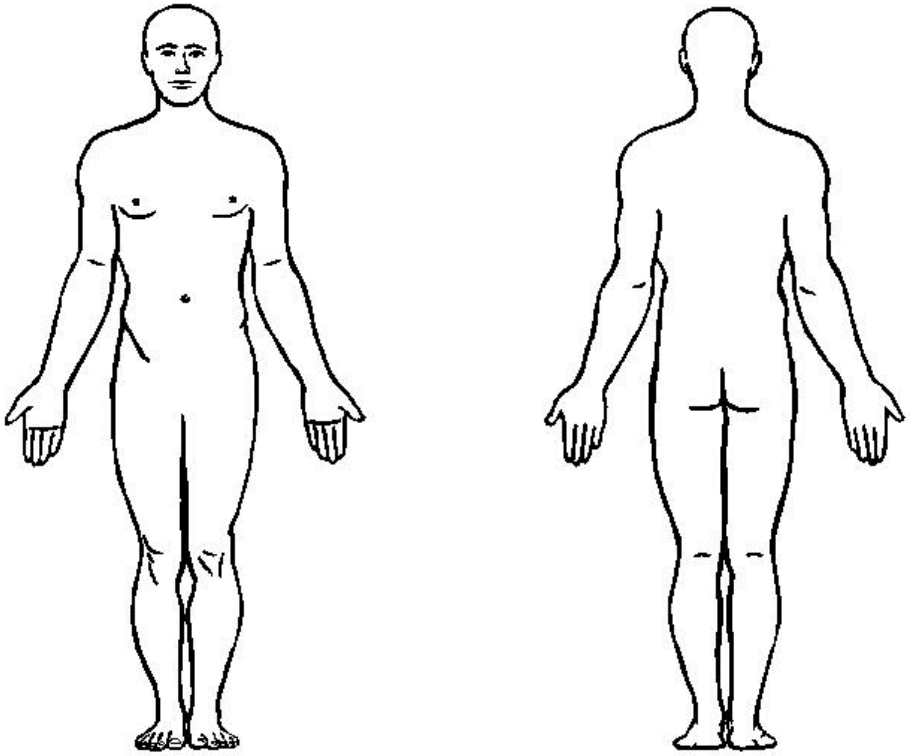
What caused this complaint? _____

When did this complaint begin? ____/____/_____ **Is it getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you had this or a similar complaint in the past? ☐ Yes ☐ No If yes, when? _____

What does your complaint(s) feel like? *Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasm / Tingling Stabbing / Shooting / Burring / Cramping / Nagging / Throbbing / Numbness / Other* _____

Please mark on the diagram to the right, the area(s) of where you have pain or other symptoms



Please rate your pain on the chart below. If you have multiple areas in pain indicate the pain level off each area.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Worst Possible Pain

Does this pain radiate, shoot or travel to other areas of the body? If so, where?

_____

_____

What Aggravates this complaint? *Circle all that apply: Sitting / Standing / Laying / Getting up from seat / Walking / Exercise Climbing stairs / Inactivity / Movement / Bending / Twisting / Reaching / Lifting / Sneezing / Coughing / Other:* ___

What relieves your complaint: *Circle all that apply: Sitting / Standing / Laying / Walking / Exercise / Inactivity / Movement Massage / Chiropractic / Heat / Ice / Wrapping /Medication / Nothing / Unknown / Other:* _____

How often do you experience your symptoms? _____

Is your complaint interfering with your: *Circle all that apply: Sleep / Getting out of bed or a chair / Personal Care / Travel Work / Recreation / Lifting / Walking Standing / Daily Actives / Social Events / Exercise / Other:*_____

Have you seen other doctors for this complaint? ☐ Yes ☐ No If yes, please provide the following information:

Doctor's name: _____ Date Consulted: _____/____/_____ Diagnosis: _____

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Patient Name: _____ **Date:** _____

What is your: **Height?** ____ Ft. ____ In. **Weight?** _____ lbs. **Age?** _____

HEALTH HISTORY Please check **ALL** of the health conditions apply to you currently or in your past

- ☐ Osteoarthritis/Degenerative Joint Disease
- ☐ Rheumatoid Arthritis
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Hypoglycemia
- ☐ High Blood Pressure / Hypertension
- ☐ Anemia
- ☐ Digestive Disorders
- ☐ Multiple Sclerosis
- ☐ Heart Disease
- ☐ Heart Attack Date: _____
- ☐ Stroke Date: _____
- ☐ Muscular dystrophy
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Irritability
- ☐ Loss of Appetite
- ☐ Difficulty Sleeping
- ☐ Unexplained Weight loss/gain
- ☐ Whiplash Injury Date: _____
- ☐ Headaches
- ☐ Migraines
- ☐ Concussion Date: _____
- ☐ Joint Pain Location: _____
- ☐ Osteoporosis/Osteopenia
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia/Chronic Fatigue
- ☐ Sexually Transmitted Infection
- ☐ Cancer Type: _____
- ☐ Genetic Disorder
- ☐ Other Medical Conditions

FAMILY HISTORY Make **ALL** conditions that run in your family, and your relations to them

- ☐ Cancer Type: _____ Relation _____
- ☐ Diabetes ☐ Type I ☐ Type II Relation _____
- ☐ Heart Attack Relation _____
- ☐ Stroke Relation _____
- ☐ High Blood Pressure Relation _____
- ☐ Rheumatoid Arthritis Relation _____
- ☐ Genetic Disorder Type: _____ Relation _____
- ☐ Other(s) Please list: _____ Relation _____

FRACTURES Broken bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date:)

_____

_____

Have you had and X-ray, CT Scan or MRI in the last 3 months? ☐Yes ☐ No

If yes, what of: _____ Center where they were taken? _____

PRESCRIPTIONS Please list **ALL** medications and supplements you are currently taking, dosage, and what it is for.

Name of Medication/Supplement	What is it for	Dosage/Frequency	Start Date / End Date

Please continue on back if you need more room.

ALERGIES Please list any known allergies you have (Hay fever, Latex, specific medication, etc.)

_____ _____

_____ _____

Please continue on back if you need more room.

WOMEN ONLY **Currently Pregnant?** ☐Yes ☐No Due Date _____ **Painful/Abnormal Menstrual Cycle?** ☐Yes ☐No

Number of Pregnancies _____ **Number of Live Births:** Vaginal ____ C-Section ____ **Menopause?** ☐ Yes ☐ No

MEN ONLY **Frequent Urination?** ☐Yes ☐No **Frequent Nighttime Urination?** ☐Yes ☐ No

Prostate pain/swelling ☐ Yes ☐No **Difficulty achieving an erection** ☐Yes ☐No

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Patient Name: _____

Financial Agreement

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment to the doctor. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of manipulation of my spine and extremities. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I also agree that I am responsible for a **$25.00 No Show Fee if an appointment is made with a Massage Therapist and I do not provide notice within 24 hours of cancelling or rescheduling**.

X-RAYS are for examinations only and the negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Should my account be turned over for collection, I, the undersigned agree to pay all costs to collect the debt, including but not limited to; interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

INSURANCE (If you intend to Self-Pay, skip to the next section on this page)

If you anticipate utilizing insurance of any type (Health, Auto, Worker's Comp, or other) *please initial this section, and sign at bottom of page*. Make sure to present **ALL** insurance cards to our staff. If you do not have an insurance card please provider your insurance information below. As a courtesy to you, we will submit your claim to insurance, and inform you of any remaining patient responsibility.

Primary Ins. _____
Policy # _____
Relationship to insured: SELF SPOUSE CHILD
Primary Insured's Name: _____
Primary Insured's D.O.B. _____

Secondary Ins._____
Policy # _____
Relationship to insured: SELF SPOUSE CHILD
Primary Insured's Name: _____
Primary Insured's D.O.B._____

_____ Initial I authorize *Advanced Spine & Health Center* to call my insurance company and verify the benefits I have available to me under my current insurance plan.

_____ Initial I hereby instruct and direct the payment of all professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy to *Advance Spine & Health Center* as for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a certain manner, any balance of said professional charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

SELF-PAY (If you intend to use insurance, fill out section above and sign below)

If you intend to use Efficient Care Solutions, a payment plan, an Exchange of Service Agreement, or any other type of self-pay, *please initial this section and sign at bottom of the page*.

_____ Initial I have **NOT** authorized *Advanced Spine and Health Center* to contact my insurance nor release of Pertinent medical information **hereby agreeing to pay any balance of Professional charges privately.**

X_____

Patient or Guardian Signature Date

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ARBITRATION AGREEMENT

Patient Name: _____

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. Arbitration can only decide a dispute between the parties and cannot consolidate or join the claims of other persons who may have similar claims.

Article 2: All claims must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether or not this document is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past present or future spouses of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient, whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care providers clinic or office or any other office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care providers associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an Arbitrator (Party Arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) will be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator will then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The party's consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this arbitration agreement. The parties further agree that the commercial Arbitration rules of the American Arbitration Association shall govern any arbitration conducted pursuant to the arbitration agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim may be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If the patient intends for this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here _____ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions, I understand that I have a right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

X_____

Patient or Guardian Signature | Signer's Printed Name | Date

X_____

Witness for ASHC | Signer's Printed Name | Date

Advanced Spine & Health Center of Cache Valley

Informed Consent to Care

Patient Name: _____

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

X_____.
Patient or Guardian Signature | Signer's Printed Name | Date

X_____
Witness for ASHC | Signer's Printed Name | Date

Advanced Spine & Health Center of Cache Valley

Patient HIPAA Acknowledgement and Consent Form

Patient Name: _____

Notice of Privacy Practice/Clinics

_____ I acknowledge that I have received the Notice of Privacy Practice, which describes the way in which Advance Spine and Health Center (ASHC) may use and disclose my healthcare information for its treatment, payment, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the ASHC. To the extent permitted by law, I consent to the use and disclosure of my information for the purpose described in the Notice of Privacy Practice.

Initial

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHO THE PROVIDER MY DISCUSS YOUR CONDITION? IF YES, WHOM? I give permission for the Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family member and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

NOTE: Patient/Representatives my revoke or Modify this Specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the ASHC may contact me for the purposes of scheduling necessary follow-up visits recommended by the chiropractor.

Consent to Email, Cellular Telephone or Text Usages for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicers have obtained, at any text number forward, or transferred from that number. These instructions may include, but are not limited to: appointment reminders, post-adjustment procedures, clinic promotions, or patient outreach.

Note: You may opt out of these communication at any time. The ASHC does not charge for this service, but standard text messaging rates or cellular minutes may apply as providers in your wireless plan (contact your carrier for pricing plans and details).

Email address: _____Cell phone: _____

Release of Information

I hereby permit ASHC to release health care information for the purposes of treatment, payment, or healthcare needs.

- Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Health care information may also be released to my employer's designee when the service delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Veteran's Administration Services, I authorize the release of healthcare information to the appropriate government agency for payment of a claim. This information may include, without limitations, health history, exam records, SOAP notes, physician progress notes, X-rays, and treatment plans.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X_____

Patient or Guardian Signature Date