



WEST MICHIGAN CHROPRACTIC CENTER, P.L.C.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy for Protected Health Information and Consent For Use or Disclosure of Health Information, currently in use by West Michigan Chiropractic Center, P.L.C. This authorization will expire seven years after the date on which you last received services from us. This notice is effective as of 12/31/02.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.

WEST MICHIGAN CHIROPRACTIC CENTER, P.L.C.

6475 BELDING RD NE, ROCKFORD, MI 49341

Treatment Consent and Payment Agreement

In consideration for the services rendered to me by West Michigan Chiropractic Center, PLC (WMCC), I hereby execute this Treatment Consent and Payment Agreement ("Agreement") and agree to the following:

CONSENT FOR TREATMENT: knowing that I desire (or the patient for whom I am signing desires) chiropractic treatment from WMCC, I do hereby voluntarily consent to such treatment by West Michigan Chiropractic staff and employees as deemed necessary in their judgment to my chiropractic care.

NO REPRESENTATIONS OR GUARANTEES: I am aware that the chiropractic treatment is not an exact science and I acknowledge that no oral or written representations, guarantees or promises have been made to me as to the results of any treatment and care that I (or patient) may receive from WMCC. I am aware that compliance with any treatment program designed by WMCC is essential to my (or the patient's) successful treatment. I understand that additional treatments may be necessary if I (or the patient) do not adhere to the prescribed treatment schedule, fail to cooperate in treatment, fail to follow exercise recommendations, or engage in activity outlined to be injurious or which causes additional trauma to the body.

RELEASE OF INFORMATION: I hereby authorize WMCC to release any information about my treatment or physical condition to any person involved in my medical or chiropractic care and any third party responsible for paying for my care, including, without limitation, records relative to claims, my employer, and any workers compensation insurance carrier engaged by my employer and to any outside peer review or auditing agency engaged in third party payer to review my medical records. WMCC may also give information to Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any other third party who may be responsible for payment of my account. WMCC may release my chiropractic records to any collection agency or attorneys it has engaged to collect any amounts due for services it has provided to me and I agree that those collection agencies or attorneys may introduce my chiropractic records as necessary in any court action to collect any amounts due for effect as long as is necessary to effectuate the purposes for which it is given.

ASSIGNMENT OF INSURANCE BENEFITS: I assign to WMCC all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for WMCC's services. I also give WMCC the right to intervene in any lawsuit or other action brought by me, or on my behalf, to collect amounts due to WMCC for services rendered to me. If I have (or the patient for whom I am signing has) insurance through Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any third party, or an automobile no fault carrier, I agree that I want WMCC to bill my insurance directly and request that any payment for insurance be made directly to WMCC. I certify that the insurance information given by me is correct. I understand that I am responsible for any balance not paid by insurance.

PAYMENT AND GUARANTY AGREEMENT: I agree to the following:

- a) In consideration for the services to be rendered by WMCC to the Patient and the Patient's representative or agent shall both be personally obligated to pay for such services in accordance with WMCC's standard rates, irrespective of whether the undersigned signs as Patient or the Patient's representative or agent. Either the Patient or the Patient's representative or agent must pay all the amounts not paid by Insurance.
- b) Payment is due in full after WMCC deposits in the mail the first bill to the Patient or the Patient's representative or agent. If the outstanding bill is not paid within 30 days after mailing the first bill, the account will be considered delinquent and a late payment charge of 0.5% per month (6% per annum) will be added to the unpaid balance 30 days after the first billing and every 30 days thereafter.
- c) In the event that the account is turned over to an attorney or collection agency for collection, the Patient or the Patients representative or agent shall pay all reasonable collection costs including attorney fees incurred by WMCC.
- d) The signature of the Patient's representative or agent does not relieve the Patient from his or her obligation to pay for services rendered.
- e) In consideration for payments that have been paid in advance for treatments not yet received, that WMCC will refund such payments within (30) thirty days of written notice from the Patient or the Patient's representative or agent.

MISCELLANEOUS: Where "I" is used in this agreement, it refers to both the Patient and the Patient's representative or agent. I understand that WMCC has no duty to investigate the authority of the Patient's representative or agent and is relying on the representation of the Patient's representative or agent that he or she has the authority required to enter into this agreement.

I UNDERSTAND THAT ANY AMOUNTS NOT PAID BY MY INSURANCE ARE MY RESPONSIBILITY.

By signing below, I acknowledge that I have read, understand and agree to the terms of this West Michigan Chiropractic Center, PLC Treatment Consent and Payment Agreement.

Printed Patient Name

Relationship (if other than Patient)

Date

Signature of Patient or Patient's representative or agent

Signature of West Michigan Chiropractic Center

West Michigan Chiropractic Center, P L.C.

Patient Registration and History

Patient Information (please print or circle information as needed) Today's Date: _____

Name: _____ Phone: _____
First MI Last

Address: _____ City _____ State _____ Zip _____

Sex: Male Female Birthdate: _____ Marital Status: Single Married

Patient Soc Sec #: _____ Email: _____

Occupation: _____

Whom may we thank for referring you? _____

In case of emergency whom may we contact? Name: _____

Relationship: _____ Home/Cell: _____ Work Phone: _____

Is condition due to an injury? Yes No If yes type of injury? Auto Work Home Other

To whom have you made a report of your accident? Auto Ins Employer Wk Comp Other

Attorney Information (if applicable) (space can also be used for auto claim # info): _____

Insurance

Will you be billing to insurance? Yes No

Signature on file

I authorize use of this form on **all** my insurance submissions. I authorize release of information to all my **Insurance Companies**. I understand that **I am responsible** for my bill. I authorize Dr. Chris Hawkins to act as **my** agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to West Michigan Chiropractic Center, P.L.C. I permit a copy of this authorization to be used in place of the original.

Printed Name: _____ Signature: _____

How long have you been experiencing the problem that brings you to the office? _____

Did it appear (circle one) Gradually Suddenly

Is there a family history of this problem? Yes No If yes please explain: _____

How often does it bother you? (circle one) Everyday 2-3 times a week A few times a month Rarely

When it's at its worst, what symptoms do you experience? _____

How does it interfere with your life? _____

Place an X in front of all of the following signs and symptoms that you have on a recurring basis. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

- headache
- fever
- chills
- night sweats
- fainting
- dizziness
- convulsions
- loss of sleep
- fatigue
- nervousness
- loss of weight
- numbness or pain in arms/legs/hands/feet
- allergies _____
- wheezing

MUSCLE & JOINTS

- weakness
- twitching (spasm)
- stiff neck
- back ache
- swollen joints
- tremors
- foot trouble
- painful tail bone
- pain between shoulders
- hernia

GASTRO-INTESTINAL

- poor appetite
- poor digestion
- excessive hunger
- belching or gas
- nausea
- vomiting
- vomiting blood
- pain over stomach
- constipation
- diarrhea
- colon trouble
- hemorrhoids
- liver trouble
- jaundice
- gall bladder trouble

CARDIOVASCULAR

- rapid heart beat
- slow heart beat
- high blood pressure
- low blood pressure
- pain over heart
- previous heart trouble
- swelling of ankles / edema
- poor circulation
- varicose veins
- history of stroke(s)

EYE EAR NOSE THROAT

- poor vision
- crossed eyes
- pain in eyes
- deafness
- earache
- ear noises
- ear discharges
- nasal obstruction
- nose bleeds
- sore throat
- hoarseness
- hay fever
- asthma
- frequent colds
- enlarged thyroid
- tonsillitis
- sinus trouble

SKIN

- acne
- itching
- bruising easily
- dryness
- boils
- sensitive skin
- hives
- eczema

RESPIRATORY

- chronic cough
 - spitting blood
 - spitting phlegm
 - chest pain
 - difficulty breathing
- GENITO-URINARY**
- frequent urination
 - painful urination
 - blood in urine
 - kidney infection
 - bed wetting
 - inability to control urine
 - prostate trouble (men)

FOR WOMEN ONLY

- painful periods
 - excessive flow
 - irregular cycles
 - hot flashes
 - cramps / back ache
 - miscarriage
 - vaginal discharge
 - pregnant at this time
- if so due date: _____

HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? PLACE AN X IF YES, LEAVE BLANK FOR NO.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> anemia | <input type="checkbox"/> heart disease | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> cancer _____ | <input type="checkbox"/> HIV/aids | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> mumps | <input type="checkbox"/> measles | <input type="checkbox"/> polio |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> vaccinations | <input type="checkbox"/> tonsillectomy | <input type="checkbox"/> tubes in ears | <input type="checkbox"/> sinus surgery |
| <input type="checkbox"/> gall bladder | <input type="checkbox"/> appendectomy | <input type="checkbox"/> female surgery _____ | <input type="checkbox"/> hernia |
| <input type="checkbox"/> rectal surgery | <input type="checkbox"/> thyroid | <input type="checkbox"/> back operations _____ | <input type="checkbox"/> stomach/ulcer |

EXERCISE

- none
- moderate
- daily
- heavy

WORK ACTIVITY

- sitting hrs/day _____
- standing hrs/day _____
- light labor
- heavy labor

HABITS

- smoking
- alcohol
- caffeine
- high stress

- packs/day _____
- drinks/week _____
- cups/day _____
- reason _____

FAMILY HISTORY

- | | | | | |
|----------|-------------|--------------|---------------|-------------|
| | DIAB | HEART | CANCER | BACK |
| mother | _____ | _____ | _____ | _____ |
| father | _____ | _____ | _____ | _____ |
| siblings | _____ | _____ | _____ | _____ |

LIST ANY ACCIDENTS OR FALLS: Vehicle: _____
Sports: _____ **School:** _____

BROKEN BONES OR DISLOCATIONS (FRACTURES): _____

OSTEOPOROSIS ? YES NO Comments _____

EVER ON CRUTCHES? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD ANY SPINAL TAPS OR INJECTIONS? YES NO IF YES, WHY? _____

WERE YOU EVER KNOCKED UNCONSCIOUS? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD A LAPSE OF MEMORY? YES NO IF YES, WHY? _____

HAVE YOU EVER HAD X-RAYS TAKEN? YES NO

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? YES NO IF YES, WHO? _____

HOW LONG AGO? _____ WHY DID YOU DISCONTINUE CARE? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, VITAMINS, HERBS, MINERALS? YES NO
IF YES, PLEASE LIST THEM: _____

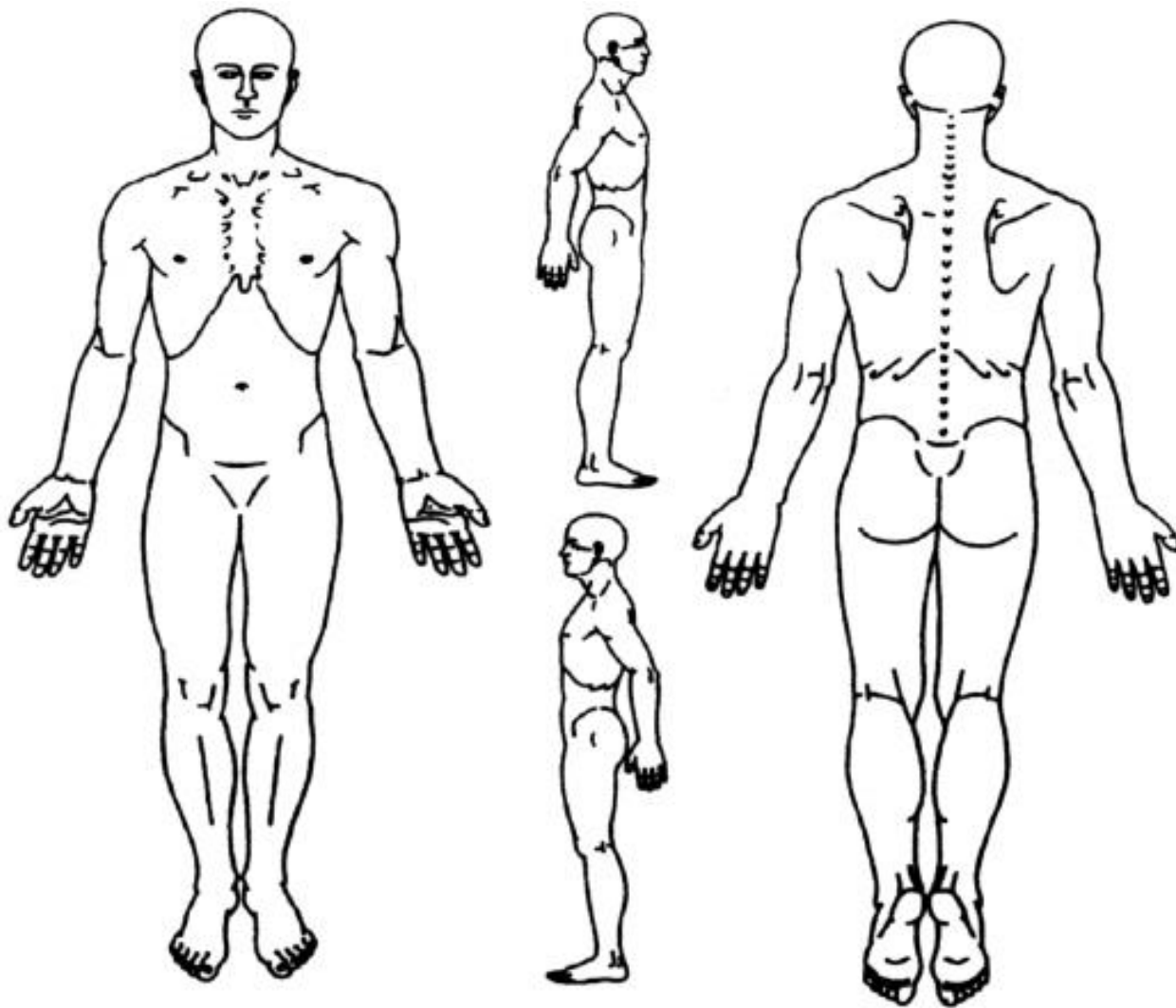
***THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS FORM TO
 ENABLE US TO BETTER CARE FOR YOUR HEALTH.***

Major Complaints:

A) _____ D) _____
B) _____ E) _____
C) _____ F) _____

On the diagram below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

Pain = P Tingling = T Numbness = N Burning = B Stiffness = S



Circle the severity of your pain on the scale of 0 – 10.

Extreme Pain

No Pain

10 9 8 7 6 5 4 3 2 1 0

Patient Name: _____ **Date:** _____