WEST MICHIGAN
CHIROPRACTIC
CENTER
DR. CHRIS HAWKINS D.C.

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.

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

EXERCISE
___ none
___ moderate
___ daily
___ heavy

WORK ACTIVITY
___ sitting
___ standing
___ light labor
___ heavy labor
hrs/day _____
hrs/day _____

HABITS
___ smoking packs/day _____
___ alcohol drinks/week _____
___ caffeine cups/day _____
___ high stress 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:

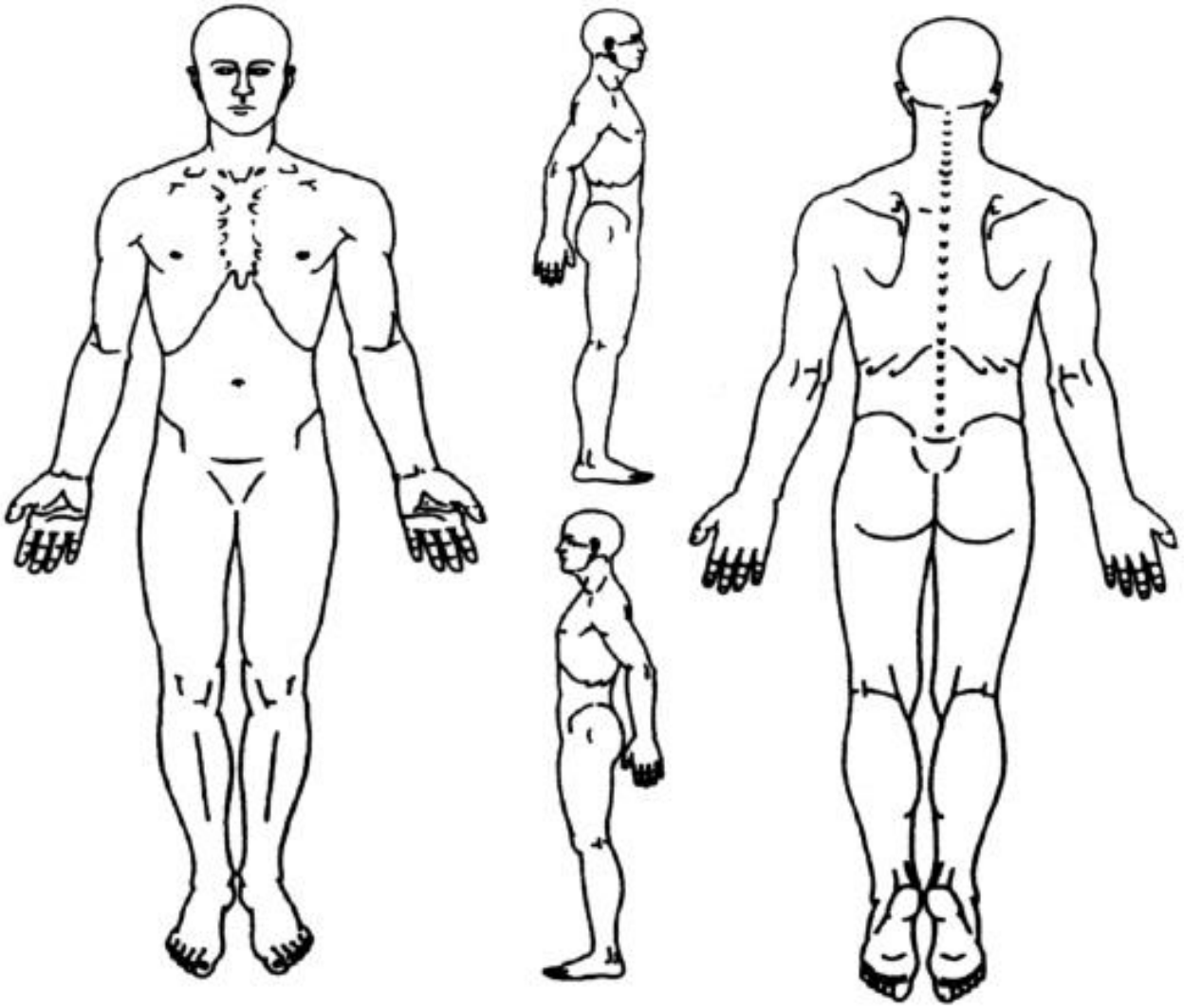
A)_____ **D)** _____

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:** _____