APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

PATIENT INFORMATION

Name_____ Birth Date_____/_____/_____ ☐ Male ☐ Female Today's Date_____

Home Address_____ City _____ State _____ Zip_____

Home Phone_____Cell Phone _____ Email_____

Social Security #_____ Employer _____Occupation:_____

Business Address_____City_____State_____Zip_____

Job Type (Circle One) FT PT Temp. Hours/week _____ How long at this position? _____ yrs/mo Married? ☐ Y ☐N ☐ Divorced

Name of Spouse _____ Spouse's Date of Birth ____/____/____ Spouse's Social Security #_____

Names and Ages of your children: _____Who referred you to our clinic? _ _____

Person Responsible for this account_____ Primary Medical Insurance [Present card(s) to staff]_____

HISTORY OF COMPLAINT

Please identify the reason/ complaint(s), injury or illnesses that brought you to this office:

_____

When did this problem(s) begin? _____Is your problem(s) the result of ANY type of accident. ☐ Yes ☐ No

If yes identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident: ____/_____/_____

Have you suffered or been treated with any of this or a similar problem(s) in the past? ❑ No ❑ Yes If yes when? _____

Who provided the treatment ☐Medical Doctor ☐ Physical Therapist ☐Osteopath ☐ Other_____

Please state what they said or recommended treatment you have tried for this problem(s)_____

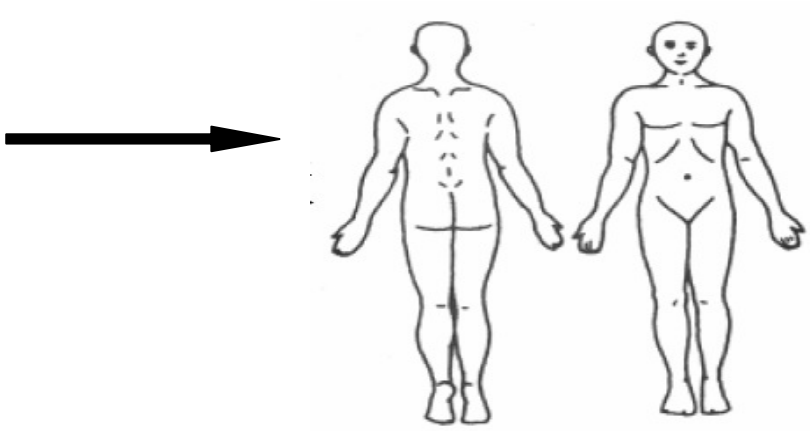
_____**when? _____**

What were the results? ☐ Favorable ☐ Unfavorable→ please explain. _____

Is this condition progressively getting worse? ☐Yes ☐ No ☐Unknown

***PLEASE MARK** the areas on the Diagram below with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp / Stabbing T = Tingling



What percentage of the day do you experience your symptoms **(Please Circle)**: Constant / Frequent / Intermittent ____%

Are your symptoms worse in the **(Please Circle)**: morning / afternoon / evening / consistent all day no change

Does it interfere with your ☐Work ☐ Sleep ☐ Daily routine ☐ Recreation

What makes them feel worse? I.e. bending, walking, exercising, sitting… _____

Describe your activities at work_____

Have you had previous chiropractic care? ☐ Yes ☐ No Name of Previous Chiropractor: _____

How long were you under care: _____What were the results? _____

Are you taking any medication(s) for complaint(s): ☐Muscle relaxers ☐ Pain killers ☐Over-the- counter_____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or staff at ADIO Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

Patient Name_____ Birth Date_____/_____/_____

NECK, BACK, EXTREMITIES Please put a check mark for symptoms you currently have or have had in the past.

NECK	Right	Left
Pain in neck	R	L
Neck Stiffness	R	L
Neck Weakness	R	L
Pinched nerve	R	L
Neck feels out of place	R	L
Muscle spasms	R	L
Grinding/popping	R	L
MID - BACK		
Mid-back pain	R	L
Mid-back stiffness	R	L
Pain between shoulder blades	R	L
Pain under shoulder blade	R	L
Pain from front to back	R	L
Muscle spasms in mid-back	R	L
LOW BACK		
Low back pain	R	L
Low back stiffness	R	L
Low back weakness	R	L
Pinched nerve in low back	R	L
Low back feels out of place	R	L
Muscle spasms in low back	R	L
Low back feels unstable	R	L

ARMS & HANDS	Right	Left
Pain in upper arm	R	L
Pain in elbow	R	L
Pain in forearm	R	L
Pain in hand	R	L
Pain in fingers	R	L
Pins & needles arm	R	L
Pins & needles fingers	R	L
Numbness in arm	R	L
Numbness in fingers	R	L
Weakness in arm	R	L
Weakness in hand	R	L
Hands Cold	R	L
HIPS, LEGS & FEET		
Pain in buttocks	R	L
Pain in hip joint	R	L
Pain down leg	R	L
Pain in knee	R	L
Pain in ankle	R	L
Pain in foot	R	L
Weakness leg/cramps	R	L

OTHER SYMPTOMS:

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past.

GENERAL	GASTROINTESTINAL	EAR, EYE, NOSE, THROAT	MEN Only	GENITO URINARY
Bruise easily	Appetite	Bleeding gums	Breast lump	Blood in urine
Chills	Bloating	Blurred vision	Erection difficulties	Frequent urination
Dental Problems	Bowel changes	Crossed eyes	Lump in testicles	Lack of bladder control
Depression	Constipation	Difficulty swallowing	Penis discharge	Painful urination
Difficulty Sleeping	Diarrhea	Double vision	Sore on penis	**CARDIOVASCULAR**
Dizziness	Excessive hunger	Earache	Other	Chest pain
Fainting	Excessive thirst	Ear discharge	**WOMEN Only**	High blood pressure
Fever	Gas	Hay fever	Abnormal pap smear	Irregular heart beat
Forgetfulness	Hemorrhoids	Hoarseness	Bleeding between periods	Low blood pressure
Headache	Indigestion	Loss of hearing	Breast lump	Poor circulation
Loss of Sleep	Nausea	Nosebleeds	Extreme menstrual pain	Rapid heart beat
Loss of weight	Rectal Bleeding	Persistent cough	Hot flashes	Swelling of ankles
Nervousness	Stomach pain	Ringing in ears	Nipple discharge	Varicose veins
Numbness	Vomiting	Sinus problems	Painful intercourse	**SKIN**
Sweats	Vomiting blood	Vision-flashes	Vaginal discharge	Bruise easily
Tiredness		Vision-halos	Other	Hives
Weight gain				Itching
				Change in moles
				Rash
				Scars
				Sore that won't heal

Date of last menstrual period_____ Date of last pap smear_____

Date of last mammogram?_____ Are you pregnant?_____ Number of Children_____

CONDITIONS / PAST HISTORY If you have ever been diagnosed with any of these conditions mark C for currently, P for past

Aids	Cataracts	Hepatitis	Mumps	Suicide attempt
Alcoholism	Chemical dependency	Hernia	Osteoporosis	Thyroid problems
Anemia	Chicken Pox	Herpes	Pacemaker	Tonsillitis
Anorexia	Diabetes	High cholesterol	Pneumonia	Tumors & growths
Appendicitis	Emphysema	HIV Positive	Polio	Typhoid fever
Arthritis	Epilepsy	Kidney disease	Prostate problem	Ulcers
Asthma	Fractures	Liver disease	Prosthesis	Vaginal infections
Bleeding disorders	Glaucoma	Measles	Psychiatric care	Venereal disease
Breast lump	Goiter	Migraine headaches	Rheumatoid arthritis	Whooping couph
Bronchitis	Gonorrhea	Miscarriage	Rheumatic Fever	Other_____
Bulimia	Gout	Mononucleosis	Scarlet Fever	_____
Cancer	Heart disease	Multiple sclerosis	Stroke	_____

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

Patient Name_____ Birth Date_____/_____/_____

MEDICATIONS List medications you are currently taking	**List VITAMINES/HERBS/MINERALS**
Allergies_____	

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s) you currently have? ❑ No ❑ Yes **If yes whom**:
❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to ADIO Chiropractic for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to ADIO Chiropractic.

_____ _____

Patient or Authorized Person's Signature **Date**

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

Functional Questionnaire

Patient Name: _____ Birth Date____/_____/_____

Activities of Daily Living: Effects of Current Condition(s) on Performance of Daily Activities. Please Circle the Appropriate Number for each Activity that Applies. Use the Pain Scale Below as a Guide.

(0)No Pain, (1)Very Mild Pain, (2)Mild Pain, (3)Very Tolerable Pain, (4)Tolerable Pain, (5)Somewhat Moderate Pain, (6)Moderate Pain, (7)Moderate-Severe Pain, (8)Severe Pain, (9)Very Severe Pain, (10)Disabling Pain.

Walking	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Sit to Stand	0	1	2	3	4	5	6	7	8	9	10
Bending	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Pushing	0	1	2	3	4	5	6	7	8	9	10
Extended Computer Use	0	1	2	3	4	5	6	7	8	9	10
Household Chores	0	1	2	3	4	5	6	7	8	9	10
Working	0	1	2	3	4	5	6	7	8	9	10
Reading/Concentration	0	1	2	3	4	5	6	7	8	9	10
Self Care - Bathing	0	1	2	3	4	5	6	7	8	9	10
Self Care - Dressing	0	1	2	3	4	5	6	7	8	9	10
Exercise / Recreation	0	1	2	3	4	5	6	7	8	9	10
Gardening	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Rolling Over	0	1	2	3	4	5	6	7	8	9	10
Watching T.V.	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Climbing Stairs	0	1	2	3	4	5	6	7	8	9	10

On a scale of 1 – 10, 10 being the highest, rate your commitment to getting rid of your problem? _____

_____

Concerns that might interfere with your commitment? (Time, Transportation, Other) Specify _____

_____

_____

_____

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

NOTICE OF HIPAA PRIVACY PRACTICE

ADIO Chiropractic is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Dr. Jeff Stickel, D.C. at 515-255-3021. If unavailable, you may make an appointment with our receptionist to see him within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: Iowa Department of Public Health, Professional Licensure Bureau, Lucas State Office BLDG, 5th Floor, 321 E. 12th Street, Des Moines, IA, 50319-0075 or call 512-281-3121 or 1-800-735-2942

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of ADIO CHIROPRACTIC Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient signature **Date**

_____ _____

Witness **Date**

_____ _____ _____ _____

Patient Signature Date Reviewed By Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC
ADIO CHIROPRACTIC POLICIES

Over time, individuals who are accepted as patients at this office gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. You consent to any perceptions others may have regarding your open bay treatment. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **ADIO CHIROPRACTIC** is rendered primarily to eliminate subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to **Activator, CBP, Diversified, Gonstead, and Pettibon**. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through three distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health. Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostic may also be ordered, to confirm the true nature and exact location of subluxations. These procedures are performed to assess your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining chiropractic amenability, as well as the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so t**h**at you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do to maintain their health for a lifetime.

☐ **PATIENT WORKSHOPS** – To enhance your understanding of the therapeutic, as well as maintenance care you will be receiving, you will be required to attend our **Advanced workshops** within the next **60** days. The information you receive will be both informative and stimulating. Afterwards you will consult privately with the doctor to discuss your x-rays and exam results as well as recommendations for care.

☐ **REFERRING TO SPECIALTY PROVIDERS** - We do not offer to diagnose or treat any diseases or condition other than vertebral subluxations. If during the course of your spinal examination, the doctor discovers an unrelated problem, you will be advised to seek a consultation with another specialty provider. Chiropractic is drugless treatment. If together we have a goal of getting off prescription medication, it is your responsibility to do so with the assistance of your medical prescriber.

☐ **FREQUENCY AND DURATION OF CARE Adults**: While pain relief may take only a few visits, getting well takes time. Generally speaking, a patient's age and life style along with the severity of the accompanying symptoms and the length of time the condition has existed will play a large role in determining the frequencies and duration of their care. The longer the subluxation has existed the more damage and the longer it will take to achieve correction and stabilization, which takes place during the final phases of a care plan; a goal which is integral to maintaining a healthy spine and nervous system.

Children: Young spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxations; therefore, it is best to check children for subluxations and begin any necessary care as young as infancy.

☐ **CARE PLAN INTERRUPTIONS** – In order to complete your first phase of care in the least amount of time with maximum results, it is vital that you follow the recommended clinical course of care outlined by your doctor without exception. That means if you miss an appointment, you must reschedule that appointment for the same or next day. **I**f you are going on vacation or out of town for an extended period of time please let the doctor know so we can provide you with additional instructions regarding the care of your condition.

☐ **TREATING DOCTOR IN CHARGE OF YOUR CASE -** Like all professions, chiropractors are required to attend continuing education classes for license renewal every year. Additionally Dr. Stickel and Dr. Ensign may be called out of town to a conference. Although Dr. Stickel or Dr. Ensign will not be available to adjust /treat patients during his/her absence another qualified doctor, familiar with your case will be managing your care until the doctor returns. It is the policy of this practice to ensure all active patients receive a continuum or uninterrupted care.

☐ **DISCONTINUING CARE** – Should you decide AT ANY TIME to discontinue care in this office, you must speak to Dr. Stickel or Dr. Ensign directly, so that an appropriate assessment as to the status of your **h**ealth t**h**at day, can be made, and documented in your record. This is particularly important if the patient should be injured in an accident in the future and a baseline for liability becomes necessary. Additionally, if you **h**ave a credit balance on your account and would like a refund it is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days of discontinuing. If it is done against the doctors advise you will be required to speak to the doctor personally or submit to the office a written statement explain your reason(s) for discontinuing care. Refunds are determined by averaging the cost per patient visit over the entire prepaid package and refunding any unused visits.

☐ **HOLIDAYS AND OFFICE VISITS AFTER HOURS** - **office are M: 6:00AM-9:30AM & 2:30PM-5:00PM; T: 2:30PM-6:00PM; W: 7-9:30AM & 2:30-5:00PM; TR: 9:00-11:00AM & 2:30-6:00PM; F: 6:00-9:30AM; Sat.: 9AM-10AM.**

If you are involved in an accident or need to be seen for any other emergency on a weekend or holiday we will be happy to see you. However, you or your insurance will be charged at our full visit rates and the prepaid plan discounts will be suspended until the treatment for the accident or emergency end.

☐ **FEES & PAYMENT FOR SERVICES** - Fees for services are due at the time services are rendered. We have two options for patients to make payment. 1. Prepay balance in full; 2. Monthly payments. We accept check, cash, credit card or Med Choice. If you have network insurance and are receiving wellness treatment, you acknowledge that your insurance does not cover your wellness treatment and you instruct us to not bill your insurance.

☐ **BILLING INSURANCE** – We ask our patients to please understand that health and accident insurance policies are a contract between them and their insurance company. We are happy to assist our patients in filing claims for reimbursement and will accept any amounts authorized by a patient to be paid directly to **ADIO Chiropractic Clinic. However, it must be clearly understood** that all services rendered are charged directly to the patient and that patients are intimately, personally responsible for payment.

☐ **CARING FOR YOUR FAMILY** - it is the policy of this practice to offer the families of all new patients the opportunity to be evaluated by ADIO CHIROPRACTIC at no charge as long as the appointment is made within 14 days from the date of your first visit.

☐ **CONSULTATIONS -** it is the policy of this practice to offer complimentary consultations to first time new patients.

_____	_____	_____	_____
Patient Signature	Date	Reviewed By	Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

ADIO Chiropractic Clinic MEDICARE POLICY

ADIO CHIROPRACTIC IS A PARTICIPATING PROVIDER

This means that we have agreed to accept assignment and receive payment from Medicare for those services considered eligible by Medicare for reimbursement. At this time Medicare's chiropractic coverage is limited to non-wellness manual manipulation of the spine. No other services will be paid for by Medicare. Before Medicare will consider reimbursement of a spinal manipulation, the doctor must verify the existence of a subluxation. Subluxations are demonstrated through the use of plain film radiography or performance of a specific examination. Because neither of these services are eligible for Medicare reimbursement it is the policy of this practice to collect those fees at the time of service, from the Medicare beneficiary.

Additionally, all Medicare patients are required to pay 100% of their charges up to $_____.00 to satisfy an annual Medicare deductible. There is also a co-payment of approximately $_____, which we collect from you at the conclusion of each visit.

Finally, Medicare does not impose a limit on the amount of chiropractic care that a beneficiary may receive per say, however they do routinely audit providers practices to ensure a very strict "***Medical Necessity"* Policy.** This means that a Medicare patient's Chiropractic Care is only eligible for reimbursement if there is evidence of a significant health condition that presents with active symptoms, and it is reasonable to expect that the care rendered will bring about considerable improvement in the patient's condition so that full function is restored within a relatively short and predictable period. When patients have achieved maximum clinical improvement, care aimed at maintaining or preserving a level of achieved functionality, or to prevent regression, or promote and enhance a quality of life will not be paid for by Medicare. ***Once you have reached this point in your care, before any further care is rendered you will be consulted so that you can make an informed decision as to whether you wish to continue chiropractic care, in as much as*** you will then be responsible for the full cost of your care each visit thereafter. Unless you experience a new injury, condition or symptoms all further care is classified as "maintenance' which Medicare deems "medically unnecessary"

I understand the limits Medicare imposes with regard to chiropractic care and that I am responsible to pay all fees for services Medicare does not cover.

*Patients' Name :*_____ *DOB:* _____ *FILE#:* _____

_____	_____	_____	_____
Patient Signature	Date	Reviewed By	Date

APPLICATION FOR CARE AT ADIO CHIROPRACTIC CLINIC

CONSENT TO TREAT A MINOR

MINOR PATIENT'S NAME: _____

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize _____ to perform imaging studies and chiropractic adjustments to my minor child, for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

_____ _____
Parent /Legal Guardian Date

_____ _____
Witness Date

_____ _____ _____ _____
Patient Signature Date Reviewed By Date