CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire in full. It will become part of your permanent record.

Name _____ Date of Birth ____ / ____ / ____ ❑ Female ❑ Male

Street Address _____ City _____ State _____ Zip _____

Social Security # ____-____-____ Phone #s: Home ( ) _____ Work ( ) _____ Cell ( ) _____

E-mail _____ ❑ I would like to receive e-newsletters and e-mail specials.

Marital Status: ❑ M Spouse's Full Name _____ ❑ S ❑ D ❑ W # of Children ___ Ages _____

Occupation _____ Employer _____

How did you hear about CAM? _____ If referred, by whom? _____

What is your major health complaint? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? ❑ Yes ❑ No

Do any positions make it feel worse? ❑ No ❑ Yes Explain _____

Do any positions make it feel better? ❑ No ❑ Yes Explain_____

Is this condition: ❑ Improved ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

Name other doctors or therapists who have treated this condition _____

List surgical operations and dates _____

Family Physician Name _____

Street Address _____ City _____ State _____ Zip _____

List medications _____

Have you been in an auto accident or had any other personal injury? ❑ No ❑ Yes Describe _____

Patient Signature _____ Date ____ / ____ / ____

Parent or Guardian Signature _____ Date ____ / ____ /

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REVIEW OF SYSTEMS - Check only the symptoms you have now, or have had in the past.

Patient Name _____ Date ____/ ____/ ____

	Current	Past
GENERAL		
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	___/____/___	
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑

	Current	Past
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑
Masses	❑	❑
BREASTS		
Nipple Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding Nipples	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloating	❑	❑
LUNGS		
Cough	❑	❑
Phlegm	❑	❑
Coughing up Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant Exposure	❑	❑
HEART		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Chest Pain/Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Bruise Easily	❑	❑
Bleed Easily	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑

	Current	Past
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloating	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Irregular Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑
Dribbling	❑	❑
Cloudy Urine	❑	❑
Urine Color _____		
Spotting Between Periods	❑	❑
Menstrual Cramps	❑	❑
Discharge	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑

Contraception Type _____
Age of 1st Period ___/___/___
Duration of Cycle _____
# of Pregnancies _____
# of Births _____
# of Miscarriages _____
# of Abortions _____
Menstrual Flow:
❑ Heavy ❑ Moderate ❑ Light
Last Period ___/___/___
Last Pap Smear ___/___/___
Last Vaginal Exam ___/___/___
Last Mammogram ___/___/___
Last Prostrate Exam ___/___/___

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REVIEW OF SYSTEMS - Page 2

Patient Name _____ Date ____/ ____/ ____

NEUROLOGICAL

	Current	Past
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Trembling Hand	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Numbness	❑	❑

ENDOCRINE

Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑

IMMUNIZATION/VACCINATION

DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑

BLOOD TYPE

❑ A+ ❑ A-
❑ B+ ❑ B-
❑ AB+ ❑ AB-
❑ O+ ❑ O-
❑ Other _____

BLOOD TRANSFUSIONS

Date ___/___/___
Date ___/___/___
Date ___/___/___
Date ___/___/___

PSYCHIATRIC

	Current	Past
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Troubled Sleep	❑	❑
Undecidedness	❑	❑
Timid	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	

MUSCLESKELETAL

	Current	Past
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Twitching	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Please check only symptoms you have had in the past:

Hay Fever	❑	Parasites	❑
Mumps	❑	Epilepsy	❑
Rheumatic Fever	❑	Paralysis	❑
Allergies	❑	Polio	❑
Angina	❑	Mental Illness	❑
Cancer	❑	Alcoholism	❑
Tumor	❑	Depression	❑
Blood Disease	❑	Nervous Breakdown	❑
Leukemia	❑	Migraine	❑
Heart Trouble	❑	Gout	❑
Varicose Veins	❑	Hemorrhoids	❑
Phlebitis	❑	Prostrate Problems	❑
Hypertension	❑	Sexual Problems	❑
Stroke	❑	Gonorrhea	❑
Ulcers	❑	Syphilis	❑
Jaundice	❑	Diabetes	❑
Skin Problems	❑	Bladder Problems	❑
Gallstones	❑	Kidney Stones	❑
Liver Problems	❑	Kidney Infections	❑
Hepatitis	❑	Dysentery	❑

Date of last Chest X-Ray ____/ ____ /____ ❑ Normal ❑ Abnormal

Last TB Skin Text ____ / ____ / ____ ❑ Normal ❑ Abnormal

Allergies: _____
_____
_____
_____

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PATIENT HISTORY

Patient Name _____ Date _____ Signature_____

FAMILY HISTORY: List any diseases on the REVIEW OF SYMPTOMS form, which run in your family.

	Age at Death	Age if Living	Cause of Death	State of Health	Illnesses
Mother					
Father					
Brother(s)					
Sister(s)					
Maternal Grandmother					
Fraternal Grandmother					
Maternal Grandfather					
Fraternal Grandfather					

SOCIAL HISTORY

Current Weight _____ Have you recently lost or gained weight? ❑ No ❑ Yes How much? _____

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day ____ Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day ____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per day ____ Days per week ____ Type _____

Smoking: ❑ Currently smoke ❑ Smoked in past Packs per Day ____ # of years ____

Alcohol: Beers per Week ____ Liquor per Week ____ Wine per week ____ # of years ____

Caffeine (coffee, tea, cola): Cups per day ____ # of years ____

Aspirin: # per day ____ # of years ____

MEDICATIONS

_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____
_____ Dosage_____ Times/day_____

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PATIENT CURRENT COMPLAINT HISTORY

Patient Name _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). The information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaint(s) and total health picture.

Please list your present complaint(s) and mark your level of pain today, for each complaint. If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ Duration – (How Long / Date): _____(Please circle one for each complaint)

No Pain **Worst Pain Imaginable**
0 1 2 3 4 5 6 7 8 9 **10**

2. _____ Duration – (How Long / Date): _____

No Pain **Worst Pain Imaginable**
0 1 2 3 4 5 6 7 8 9 **10**

3. _____ Duration – (How Long / Date): _____

No Pain **Worst Pain Imaginable**
0 1 2 3 4 5 6 7 8 9 **10**

Were you treated for these episodes? ❑ No ❑ Yes If yes, by whom? _____
How did your symptoms begin? ❑ Immediately after a specific incident ❑ After multiple incidents ❑ Gradually developed over time ❑ Other _____
What makes your symptoms better? ❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other _____
What makes your symptoms worse? ❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other _____
Are your symptoms? ❑ Decreasing ❑ Increasing ❑ Not Changing ❑ Other _____

Description of pain or symptoms:

❑ Sharp ❑ Shooting
❑ Dull ❑ Burning
❑ Ache ❑ Numb
❑ Weakness ❑ Tingling
❑ Throbbing ❑ Other _____

Does your pain move or radiate? ❑ No ❑ Yes Where _____
Check the best and worse times of day for your pain:

Worse	Best
❑ First Awake	❑ First Awake
❑ Morning	❑ Morning
❑ Afternoon	❑ Afternoon
❑ Evening	❑ Evening
❑ Night time	❑ Night time
❑ Other	❑ Other _____

Frequency of pain or symptoms:

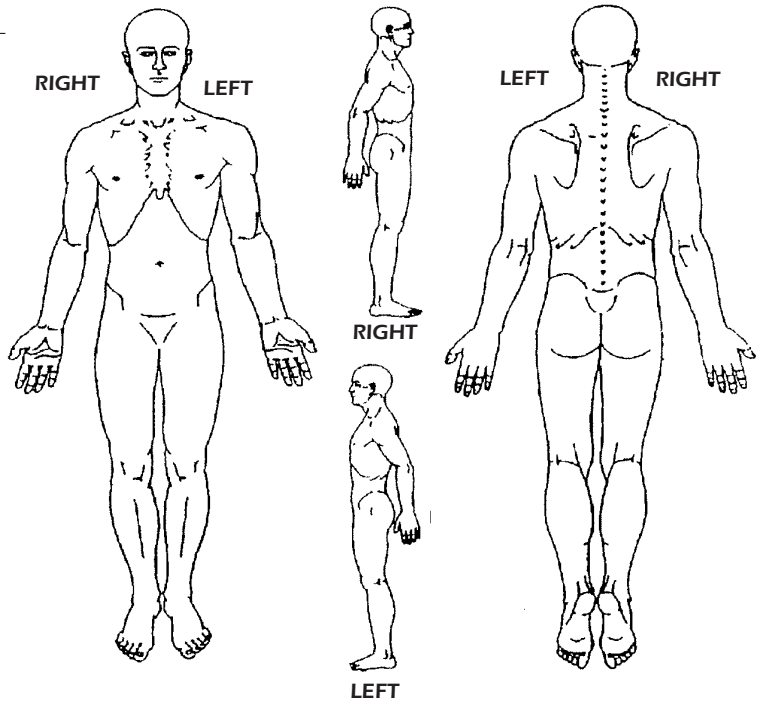
❑ Constant (76 – 100%)
❑ Frequent (51 – 75%)
❑ Occasional (26 – 50%)
❑ Intermittent (25% or less)

How many days out of an average week are you in pain?
(Please circle one.) 1 2 3 4 5 6 7

How much time during the day are you in pain?
❑ less than 1 hour ❑ 1 to 6 hours ❑ 6 to 12 hours
❑12 to 18 hours ❑18 to 24 hours ❑ 24 hours

SHOW US YOUR PAIN

Use the letters below to indicate the type and location of your symptoms today:
C = Constant **A** = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles
S = Stabbing **H** = Sharp **X** = Stiffness **T** = Throbbing **O** = Other



Patient or Guardian's Signature _____ ❑ Patient ❑ Guardian Date ____ / ____ / ____

OUCH!

ACCIDENTS • ACHES • ALLERGIES • BUMPS • COLDS • CONSTIPATION • FALLS • FATIGUE • HEADACHES • INDIGESTION • NERVOUSNESS • SELF-ADMINISTERED TREATMENT • SLEEPLESSNESS • STIFFNESS • STOMACH TROUBLE • TENSION

If you have experienced a sudden change in your physical condition, we would like to know about it, because we want your treatment to be the best possible for your present state. Your complete recounting of any discomfort you have felt, and any accidents or injuries you have had recently, even if you experienced no apparent reaction, will help us help you more. Please provide the following information:

List any out-of-the-ordinary pains, discomfort, or other symptoms you have experienced since your last visit: _____

_____

_____

_____

_____

_____

_____

_____

_____

What have you done to try to relieve your symptoms? _____

_____

_____

_____

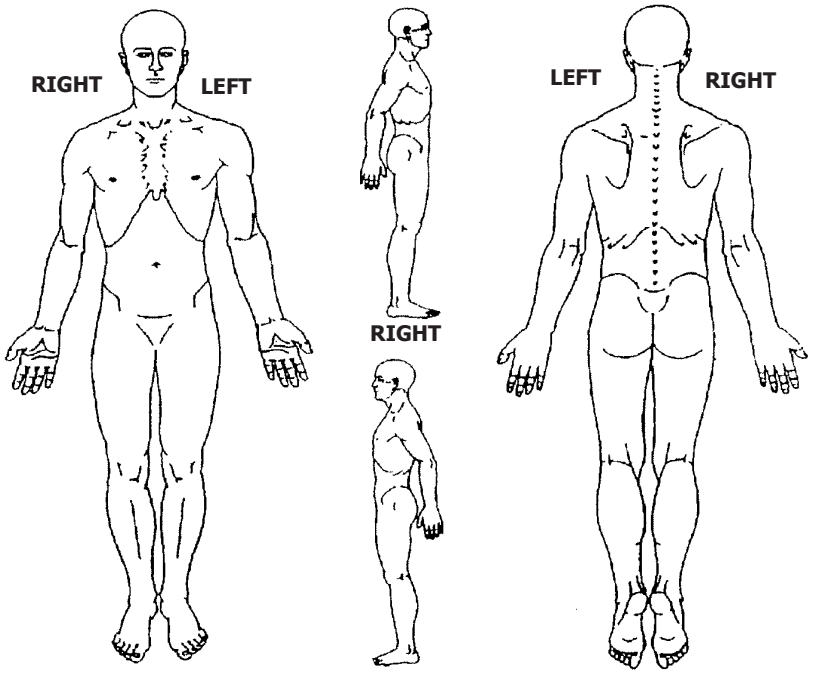
_____

_____

SHOW US YOUR PAIN

Use the letters below to indicate the type and location of your symptoms today:

C = Constant **A =** Ache **B =** Burning **N =** Numbness **P =** Pins & Needles
S = Stabbing **H =** Sharp **X =** Stiffness **T =** Throbbing **O =** Other



Other comments: _____

_____

_____

Print Name _____ Signature _____ Date ____ / ____ / ____

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LOW BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____ / ____ / ____

NOTE: This questionnaire has been designed to enable your Doctor to understand how your back pain has affected your ability to manage everyday life. **Please answer every section, and circle the answer that most closely describes your current symptoms. Circle only 1 answer per section.**

SECTION A - Pain Intensity
1. I can tolerate the pain without using pain killers
2. The pain is bad but I can manage without pain killers
3. Pain killers give complete relief from pain
4. Pain killers give moderate relief from pain
5. Pain killers give very little relief from pain
6. Pain killers have no effect on the pain & I do not use them

SECTION B - Personal Care
1. I can look after myself normally without causing extra pain
2. I can look after myself normally, but it causes extra pain
3. It is painful to look after myself and I am slow & careful
4. I need some help but manage most of my personal care
5. I need help everyday in most aspects of self care
6. I do not get dressed. I wash with difficulty & stay in bed

SECTION C - Lifting
1. I can lift heavy loads without extra pain
2. I can lift heavy loads, but it gives me extra pain
3. Pain prevents me from lifting heavy loads off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy loads, but I can manage light to medium, if they are conveniently positioned
5. I can only lift very light loads, at most
6. I cannot lift or carry anything, because of he pain

SECTION D - Walking
1. Pain does not prevent me from walking any distance
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than 1/2 mile
4. Pain prevents me from walking more than 1/4 mile
5. I can only walk using a cane or crutches
6. I am in bed most of the time and have to crawl to the toilet

SECTION E - Sitting
1. I can sit in any chair as long as I like without pain
2. I can only sit in my favorite chair as long as I like
3. Pain prevents me from sitting more than an hour
4. Pain prevents me from sitting more than 30 minutes
5. Pain prevents me from sitting more than 10 minutes
6 Pain prevents me from sitting almost all the time

SECTION F - Standing
1. I can stand as long as I want without pain
2. I can stand as long as I want but it gives extra pain
3. Pain prevents me from standing more than 1 hour
4. Pain prevents me from standing more than 30 minutes
5. Pain prevents me from standing more than 10 minutes
6. Pain prevents me from standing at all

SECTION G - Sleeping
1. I have no pain in bed
2. I can sleep well only by using tablets
3. Even when I take tablets I have less than 6 hours sleep
4 . Even when I take tablets I have less than 4 yours sleep
5. Even when I take tablets I have less than 2 hours sleep
6. I cannot sleep, because of the pain

SECTION H - Social Life
1. My social life is normal and gives me no pain
2. My social life is normal, but increases the degree of my pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
4. Pain has restricted my social life and I do not go out very much anymore
5. Pain has restricted my social life to my home
6. I have hardly any social life, because of the pain

SECTION J - Traveling
1. I have no pain while traveling
2. I can travel anywhere but it gives me extra pain
3. Pain is bad but I manage journeys over 2 hours
4. Pain is bad but I manage journeys less than 1 hour
5. Pain restricts me to short necessary journeys under 30 minutes
6. Pain prevents all forms of travel except to the doctor or hospital

SECTION K - Changing Degree of Pain
1. My pain is rapidly getting better
2. My pain fluctuates, but overall is definitely getting better
3. My pain seems to be getting better, but improvement is slow
4. My pain is neither getting better nor worse
5. My pain is gradually worsening
6. My pain is rapidly worsening

COMMENTS: _____

_____

_____

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NECK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____ / ____ / ____

NOTE: This questionnaire has been designed to enable your Doctor to understand how your back pain has affected your ability to manage everyday life. **Please answer every section, and circle the answer that most closely describes your current symptoms. Circle only 1 answer per section.**

SECTION A - Pain Intensity
1. The pain comes and goes and is very mild
2. The pain is mild and does not vary much
3. The pain comes and goes and is moderate
4. The pain is moderate and does not vary much
5. The pain comes and goes and is severe
6. The pain is severe and does not vary much

SECTION B - Personal Care
1. I have not had to change my way of washing or dressing in order to avoid pain
2. I do not normally change my way of washing or dressing, even though it causes some pain
3. Washing and dressing increases the pain, but I manage not to change my way of doing it
4. Washing and dressing increases the pain and I find it necessary to change my way of doing it
5. Because of the pain, I am unable to do some washing and dressing without help
6. Because of the pain, I am unable to do any washing or dressing without help

SECTION C - Lifting
1. I can lift heavy loads without extra pain
2. I can lift heavy loads, but it give me extra pain
3. Pain prevents me from lifting heavy loads off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy loads, but I can manage light to medium, if they are conveniently positioned
5. I can only lift very light loads, at most
6. I cannot lift or carry anything, because of the pain

SECTION D - Reading
1. I can read as long as I want, with no pain in my neck
2. I can read as long as I want, with slight pain in my neck
3. I can read as long as I want with moderate pain in my neck
4. I can't read as much as I want, because of moderate pain in my neck
5. I can hardly read at all, because of severe pain in my neck
6. Pain prevents me from reading at all

SECTION E - Headaches
1. I have no headaches at all
2. I have slight headaches that come infrequently
3. I have slight headaches that come frequently
4. I have moderate headaches that come infrequently
5. I have moderate headaches that come frequently
6 I have severe headaches, which come frequently
7. I have headaches almost all the time

SECTION F -Concentration
1. I can concentrate fully with no difficulty
2. I can concentrate fully with slight difficulty
3. I have a fair degree of difficulty concentrating
4. I have a lot of difficulty concentrating
5. I have a great deal of difficulty concentrating
6. I cannot concentrate at all, because of the pain

SECTION G - Work
1. I can do as much work as I want
2. I can do all of my usual work, but no more
3. I can do most of my usual work, but no more
4. I cannot do my usual work
5. I can hardly do any work at all
6. I can't work at all, because of the pain

SECTION H - Driving
1. I drive without any pain
2. I can drive as long as I want, with slight pain in my neck
3. I can drive as long as I want, with moderate pain in my neck
4. I can't drive as long as I want, because of moderate pain in my neck
5. I can hardly drive at all, because of severe pain in my neck
6. I can't drive at all, because of the pain

SECTION I - Sleeping
1. I can sleep with no pain at all
2. My sleep is slightly disturbed (less than 1 hr. sleeplessness)
3. My sleep is moderately disturbed (1-2 hrs. sleeplessness)
4 . My sleep is moderately disturbed (2-3 hrs. sleeplessness)
5. My sleep is greatly disturbed (3-4 hrs. sleeplessness)
6. I cannot sleep, because of the pain

SECTION J - Recreational Activities
1. I am able to participate in all my recreational activities with no neck pain at all
2. I am able to participate in all of my recreational activities, with some pain in my neck
3. I am able to participate in most, but not all, of my usual recreational activities, because of the pain in my neck
4. I am able to participate in a few of my usual recreational activities, because of the pain in my neck
5. I can hardly do any recreational activities, because of the pain in my neck
6. I can't do any recreational activities at all, because of the pain

COMMENTS: _____

_____

_____

CONTACT INFORMATION

Date _____

Patient name (please print) _____

E-mail address _____

Please list any phone numbers that we have permission to use to confirm your appointments,
Put a check mark next to the phone number to call first.

Home (____) _____

Work (____) _____

Cell (____) _____

Other (____) _____

I realize that reminder calls are done as a courtesy. Ultimately, it is my responsibility to know my appointment date and time. I am aware that any missed appointments could result in an office visit charge.

_____ _____
Signature Date

EMERGENCY CONTACT INFORMATION

Please give an emergency contact. Put a check mark next to the phone number to call first.

Contact name _____ Relationship _____

Home (____) _____

Work (____) _____

Cell (____) _____

Primary Care Physician: Name _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
http://www.chirowarren.com/
A non-partnership of independent practitioners

586 / 293 - 4440 • Fax 586 / 293 - 0840

Rev. 3/6/08

HIPAA: CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that the Chiropractic Associates of Michigan Notice of Privacy Practices has been provided to me.

I understand my right to review the Chiropractic Associates of Michigan (CAM) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CAM. This Notice of Privacy Practices also describes my rights and CAM duties with respect to my protected health information. The Notice of Privacy Practices for CAM can be provided, on request, at the front desk.

Chiropractic Associates of Michigan reserves the right to change the privacy practices described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed, or by asking for a copy at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that CAM has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of a copy of this notice, and my understanding, and agreement, to the terms:

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. I authorize you to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

2. I authorize my attorney to make direct payments to you of any sum I now, or hereafter, owe. Payment is to be taken out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to myself or you based, in whole or in part, upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to myself, or to you, for the charges for chiropractic services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the pertinent data below) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that I am responsible for paying whatever amounts not collected from insurance proceeds (whether it be all or part of what is due).

INSURANCE PAYMENT AGREEMENT

Dear Patient,

Discrepancies can occur between information provided to us by your insurance company and what your insurance actually covers. Due to the unpredictable nature of insurance billing, it is possible that your insurance company may raise payment questions regarding coverage of payment.

YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED.

Most insurance companies provide literature outlining the specifics of their coverage. Please refer to this literature, or contact your insurance company directly, to answer any questions regarding your chiropractic health care coverage.

I have read and understand all of the above:

_____ _____

Patient Signature Date

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INFORMED CONSENT FOR EXAMINATION & TREATMENT

I hereby consent to the performance of examination and treatment on me by the licensed Doctors of Chiropractic, and/or therapists who may be employed or engaged in practice in this clinic.

I have an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care my involve judgment to attempt to anticipate or explain risks and complication and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care, which includes rarely, but not limited to fractures, disc injuries, strokes and strain/sprains, and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained, regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition, and for any future conditions for which I seek treatment.

Print Patient Name _____ Patient Signature _____

Date _____

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Rev. 9/28/10

MISSED APPOINTMENTS POLICY

We ask for your assistance and cooperation in keeping your scheduled appointment date and time.

It is our policy that if a patient misses or cancels an appointment with less than 24 hours notice, that patient will be charged the regular office visit fee for that time. This policy is necessary to avoid the numerous schedule problems that last minute cancellations and missed appointments create!

If the need arises to cancel or change your appointment, we would appreciate 48 hours notice, when possible, but no less than 24, to avoid an unnecessary charge to you.

We thank you for your cooperation and look forward to being a vital part of your health care and maintenance.

I have read and understand the above policy:

Patient Signature _____ Date _____

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8272020

DR. LIPSON PATIENTS: NON-COVERED FEES

Some fees that are part of your treatments are not covered by insurance. These charges are the patient's responsibility, and are as follows:

FUNCTIONAL MUSCLE TESTING: $28.00
Functional Muscle Testing allows your doctor to analyze problem areas specific to your condition. This directs your doctor in determining the course of treatment to be applied to correct the problem area(s).
Functional Muscle Testing is performed for each treatment visit.

The functional Muscle Testing procedures are integral and necessary components of your health care plan, moving forward toward your health improvement goals.

I have read, and agree to pay the above fee:

Patient or Guardian Name (print) _____ Date ____ / ____ / ____

Signature _____

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15-BCBS

40517

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31850 SCHOENHERR / WARREN, MI 48088
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http://www.chirowarren.com/

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Dr. Lipson Patients:

VOLUNTARY RECOMMENDED SERVICES NOT COVERED BY BCBSM

Patient Name or Representative (print): _____

Retainer Period Start: _____ End: _____

In exchange for the fees outlined below and paid by you, Dr. Lipson agrees to provide you with the Services described below in this Agreement, on the terms and conditions set forth in this Agreement.

YOU ARE AGREEING TO PAY DR. LIPSON FOR ALL SERVICES NOT SPECIFIED IN THE BCBSM AGREEMENT AND NOT OTHERWISE COVERED BY INSURANCE.

DR. LANNY LIPSON, CHIROPRACTIC ASSOCIATES OF MICHIGAN, AND YOU ARE PROHIBITED FROM BILLING AN INSURER OR OTHER THIRD PARTY PAYER FOR SERVICES NOT PROVIDED BY BCBSM, AS STIPULATED UNDER THIS AGREEMENT.

	BCBSM APPROVED COSTS	PATIENT AGREED RESPONSIBILITY
Each Visit	BCBSM Approved Charges	$28.00 Muscle Testing Fee

Services Provided Under the Agreement: Second visit fee (new patients, one time only fee), reevaluation, treatment protocol considerations and report of findings.

Functional muscle testing; Implementation of specific muscle testing protocols are performed each patient treatment visit. Positive findings are used to determine specific musculoskeletal imbalances utilized to uncover hidden or deeper areas of neuromuscular and muscleskeletal disharmony, for treatment and promotion of better health and wellnesss.

Termination: Either party shall have the absolute and unconditional right to terminate this agreement, with or without cause, upon giving 30 days prior written notice to the other party. This agreement shall also terminate upon the death of the physician or the patient[s].

Unless terminated, at the expiration of the initial term (and each succeeding term), the Agreement will automatically renew for successive terms upon the payment of the fee described above. If the Agreement is terminated prior to the end of the agreement, the remaining prorated portion of fees paid will be returned to the Patient(s).

_____ _____/_____/_____

Patient or Representative Signature Date