ASPEN
CHIROPRACTIC & WELLNESS

PATIENT INFORMATION WELLNESS

Thank you for choosing Aspen Chiropractic and Wellness. Please place a line through any area that does not apply.Please don't hesitate to ask if you need assistance.

GENERAL INFORMATION

Name: _____ Date: _____ S.S. # _____
First M.I. Last

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____/_____/_____ Gender: ☐ Female ☐ Male Email: _____

Hm Ph: (_____) _____ Cell Ph: (_____) _____

How did you hear about us? _____

Patient Employer/School: _____ Spouse/Parent'sName:_____

Emergency Contact / Relationship: _____ Ph: (_____) _____

Primary Care Provider: _____ Phone number: _____

Preferred Pharmacy: _____ Phone number: _____

INSURANCE INFORMATION

Who is responsible for this account: _____ Relationship to Patient: _____

Insurance Company: _____ Policy #: _____Group#: _____

Is the patient covered by additional insurance? ☐ Yes ☐ No

If yes which Insurance Company: _____ Policy #: _____ Group#: _____

MEDICATIONS: Please list **all current** medications (prescribed or over the counter)/supplements

Medications/Supplements	Reason taking	Start Date

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MEDICATION ALLERGIES	REACTION

PAST SURGERIES / HOSPITALIZATIONS	DATE

MEDICAL HISTORY

CONDITION	SELF	FAMILY MEMBER (indicate if on maternal/paternal side)
Heart Disease		
High Blood Pressure		
Cholesterol/Lipid Problems		
Stroke		
Diabetes		
Arthritis (indicate type)		
Osteoporosis		
Headaches		
Kidney Problems		
Liver Problems		
Seizures		
Cancer (indicate type)		
Autoimmune Disorder		
Thyroid Problems		
Other		

SOCIAL HISTORY

Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Minor

Do you have children? Yes No How many? _____ Ages? _____

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Daily Habits

What type of exercise do you do? _____ How often? _____

Occupation _____ Previous Occupation:_____

Do you work: ☐ Days ☐ Nights Have you ever worked nights? ☐ Yes ☐ No Hours worked per day? ___

What do your daily work habits include? (Ex. Sitting, standing, light labor, heavy labor, computer work)

_____

Do you smoke or use other tobacco products? Yes No How much per day? _____

Drug use? Yes No If yes, type?_____

How much alcohol or liquor do you consume weekly? _____

How much stress do you have? None Light Moderate Severe

Rate your energy level 0 1 2 3 4 5 6 7 8 9 10 (10 is the highest or best you can feel)

REVIEW OF SYSTEMS/MEDICAL ISSUES

PLEASE CIRCLE THE APPROPRIATE RESPONSES BELOW

DATE OF LAST PHYSICAL __/__/____ BLOOD WORK __/__/____

General

Fatigue	**Present Past N/A**	**Hot /Cold Often**	**Present Past N/A**	**Insomnia**	**Present Past N/A**
Night sweats	**Present Past N/A**	**Tremors**	**Present Past N/A**	**Toss/Turn at Night**	**Present Past N/A**
Vitamin D Def.	**Present Past N/A**	**Bruise Easily**	**Present Past N/A**	**Decreased motivation**	**Present Past N/A**
Diabetes	**Present Past N/A**	**Fevers**	**Present Past N/A**	**Cancer (type)**	**Present Past N/A**

HEAD, EYES, EARS, NOSE AND THROAT

Headaches	**Present Past N/A**	**Hearing Issues**	**Present Past N/A**	**Eye Problems**	**Present Past N/A**
Migraines	**Present Past N/A**	**Sore Throats**	**Present Past N/A**	**Head injury**	**Present Past N/A**
Thyroid Issues	**Present Past N/A**	**Sinus Problems**	**Present Past N/A**	**Allergies**	**Present Past N/A**
Dental problems	**Present Past N/A**	**Sinus Drainage or Congestion**	**Present Past N/A**	**Other:**	

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CARDIOVASCULAR

Chest Pain	Present Past N/A	Poor circulation	Present Past N/A	High blood pressure	Present Past N/A
Heart attack	Present Past N/A	Pacemaker	Present Past N/A	High cholesterol	Present Past N/A
Stroke	Present Past N/A	Swelling in feet	Present Past N/A	Irregular heartbeat	Present Past N/A
Fainting	Present Past N/A	CHF	Present Past N/A	DVT or blood clots	Present Past N/A
Murmur	Present Past N/A	MVP	Present Past N/A	Other:	

RESPIRATORY

Asthma	Present Past N/A	Pneumonia	Present Past N/A	Shortness of breath	Present Past N/A
Cough	Present Past N/A	Bronchitis	Present Past N/A	Other:	Present Past N/A

GASTROINTESTINAL

Acid Reflux	Present Past N/A	Nausea/Vomiting	Present Past N/A	Abdominal pain	Present Past N/A
GI bleeding	Present Past N/A	Diarrhea	Present Past N/A	Abdominal cramps	Present Past N/A
Liver problems	Present Past N/A	Constipation	Present Past N/A	Other:	

GENITOURINARY

Bladder Issues	Present Past N/A	Kidney Issues	Present Past N/A	Other:	

MUSCULOSKELETAL

DATE OF LAST DEXA SCAN __/__/___ NA

Neck pain	Present Past N/A	Muscle spasms	Present Past N/A	Fibromyalgia	Present Past N/A
Back pain	Present Past N/A	Osteoporosis	Present Past N/A	Osteoarthritis	Present Past N/A
Joint pain	Present Past N/A	Joint Injury	Present Past N/A	Rheumatoid Arthritis	Present Past N/A
Muscle pain	Present Past N/A	Broken bone	Present Past N/A	Slow muscle recovery:	Present Past N/A
Muscle stiffness	Present Past N/A	Carpal tunnel	Present Past N/A	Other:	

NEUROLOGICAL

Neuropathy	Present Past N/A	Poor memory	Present Past N/A	Poor Concentration	Present Past N/A
Numbness	Present Past N/A	ADD	Present Past N/A	Seizure disorder	Present Past N/A
Tingling	Present Past N/A	ADHD	Present Past N/A	Other:	

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REPRODUCTIVE (FEMALE)

DATE OF LAST PAP __/__/____ MAMMO __/__/____

ARE YOU PREGNANT? Yes No **ARE YOU TRYING TO BECOME PREGNANT?** Yes No

Menstrual Cycles	Present Past N/A	Decreased Libido	Present Past N/A	Vaginal Dryness	Present Past N/A
Regular Cycles	Present Past N/A	PMS	Present Past N/A	Pain with sex	Present Past N/A
Heavy Cycles	Present Past N/A	Mood swings	Present Past N/A	Abnormal Pap	Present Past N/A
Menstrual Cramps	Present Past N/A	Emotional	Present Past N/A	Abnormal Mammo	Present Past N/A
Fertility issues	Present Past N/A	PCOS	Present Past N/A	Fibrocystic breast	Present Past N/A
Endometriosis	Present Past N/A	Ovarian Cysts	Present Past N/A	Other breast issues:	Present Past N/A
Menopause	Present N/A	Hot flashes	Present Past N/A	Other:	
Hysterectomy If yes, full or partial	Yes No	Birth control use If yes, for how long?	Present Past N/A	Other:	

REPRODUCTIVE (MALE)

Last Prostate Exam __/__/____ NA

Decreased Libido	Present Past N/A	Morning erections	Present Past N/A	Decreased quality or duration of erections	Present Past N/A
Fertility Issues	Present Past N/A	Enlarged Prostate	Present Past N/A	Testicular Trauma	Yes No
Planning on having children?	Yes No	Other:		Other:	

HAIR/SKIN/NAILS

Rash	Present Past N/A	Pruritis (itching)	Present Past N/A	Hair loss	Present Past N/A
Hives	Present Past N/A	Excema	Present Past N/A	Excess Hair	Present Past N/A
Acne	Present Past N/A	Dry or Oily Skin	Present Past N/A	Other:	

PSYCHOSOCIAL

Anxiety	Present Past N/A	Stress Problems	Present Past N/A	Increased Irritability	Present Past N/A
Depression	Present Past N/A	Drug or alcohol issues	Present Past N/A	Other:	

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Reason(s)for you visit today? _____

_____

Rate the severity of your symptoms with 10 being the max or worst symptoms could be:

Symptom 1 _____ 0 1 2 3 4 5 6 7 8 9 10

Symptom 2 _____ 0 1 2 3 4 5 6 7 8 9 10

Symptom 3 _____ 0 1 2 3 4 5 6 7 8 9 10

Symptom 4 _____ 0 1 2 3 4 5 6 7 8 9 10

When did you first notice the symptom (s) _____

Have you had this in the past? Yes No If Yes, how long ago? _____

How long did it last? _____ How did it resolve? _____

How did current symptoms begin? Suddenly or Gradually

What caused your current symptoms if it began suddenly? _____

What are you doing for your symptoms now? _____

Are you taking medications/supplements for these symptoms? _____

_____

Are your symptoms getting better/worse/or staying the same? _____

What makes your symptoms better? _____Worse?_____

Have you seen any other medical provider or Chiropractor for your symptoms? Yes or No

If yes, when/where? _____

Is there anything else about your symptoms that you want us to know? _____

Consent to Treat

By signing below I am indicating that the above information is correct. I also give the providers and staff at Aspen Chiropractic and Wellness permission to treat my condition as deemed necessary.

_____ _____

Patient Signature / Guardian Signature

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WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at any time. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

Insurance Patients: Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. ***Deductibles are the patients' full responsibility.*** If you fail to keep your appointments or you discontinue care for any reason other than discharge by the Provider, the bill is due and payable by you in full immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group insurance policies, Personal Injury Claims, and authorized Worker's Compensation. If the provider, as part of a treatment plan prescribes manual therapy for you, you must see the provider on the same day of service. If you do not, you are responsible for the full amount of the service.

Collection/Attorney Fees: I agree to pay all costs of a collection agency if necessary, not to exceed 25% of the principle, to obtain payment in the event that legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Limited Release of Medical Information: I authorize Aspen Chiropractic to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these circumstances.

Assignment of Cause of Action: In the event that any insurance company or other third party obligated to make payment to me or to Aspen Chiropractic for the charges made for these services refuses to make such payment on demand, I hereby assign, transfer, and convey to Aspen Chiropractic any and all cause of action that might exist in my favor against any such company or person. I authorize Aspen Chiropractic to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

By signing this statement, I am agreeing to all above notices. I have reviewed a copy of the Notice of Privacy Practices and may request a copy at any time.

_____ _____

Patient Signature / Guardian Signature Date

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Dr. Shane McCall, D.C. Carli Walter, P.A.-C Dr. Brian Glick, D.O. Dr. Joseph Vigneau, D.C.
21681 N. 77th Ave. · Suite 1415 · Peoria, AZ · 85382

Others Involved in My Healthcare

Patient Name:_____ ID Number:_____

Aspen Chiropractic and Wellness, ***MAY*** discuss all aspects of my healthcare with:

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Signature of Patient or Legal Representative Date

Aspen Chiropractic and Wellness, ***MAY NOT*** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.*

*As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Signature of Patient or Legal Representative Date

A complete copy of our Notice of Privacy Practice is available at this office for you at any time.

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You have the right to rescind any part of this authorization with written notice.

PAYMENT POLICY AND BENEFIT ASSIGNMENT

Our practice is committed to providing you with the best quality and affordable medical care.
Please review our financial policy.

1. Insurance: We participate in most insurance plans. If you are not insured nor have a plan that we do not participate in, payment is expected in full at the time of your visit. It is the patient's responsibility to make sure that our office keeps your current insurance information. If you have any questions regarding coverage, please contact your insurance company directly.

2. Co-payment: All co-payments are due at the time services are rendered. For your convenience we accept Visa, MasterCard, AMEX, Checks or Cash.

3. Non-Covered Services: All non-covered services by insurance will be the responsibility of the patient.

4. Updates: Our staff will verify your information at each visit. It is the patient 's responsibility to update with opportunity all personal/insurance information updates or changes.

5. Claims submission: Aspen Chiropractic and Wellness will submit your claims and assist you in any way we can to help get your claims paid. *It is your responsibility to comply in a timely manner to ensure coverage and payment.* Please note that the *balance of your claim is your responsibility whether or not your insurance pays your claims.* Your insurance benefit is a contract between you and your insurance company.

6. Delinquent Accounts: Accounts past due 60 days will receive a 10 day-grace period to bring your account to good standing. If a balance remains unpaid, your account will be referred to a collection agency. A fee of $50.00 will be added to any outstanding balance. Please contact our office if you desire to make payment arrangements with opportunity.

7. Referrals and Authorizations: If a referral is needed by your insurance, you will be asked to obtain a referral prior to your visit. We suggest you contact your insurance company to verify coverage, benefits and pre-authorizations requirements before your visit. Please be aware that referral and authorizations are not a guarantee of payment.

8. Missed Appointments:

Wellness Appointments: A $75.00 fee will be applied to those appointments not canceled with 24 hours of anticipation.

Massage Appointments: A $50.00 fee will be applied to those appointments not canceled with 24 hours of anticipation.

9. Returned checks (NSF): A $50.00 fee will be charged for any personal check returned for non-payment.

I hereby acknowledge that I have been presented with a copy of Aspen Chiropractic and Wellness Payment Policy and Benefit Assignment.

_____ _____

Patient Signature / Guardian Signature Date