Turning Thin Air Into Gold

Sport Chiropractic & Performance Training
Dr. Wes Gregg DC
&
Dr. AJ Gregg DC CSCS MS

Health History Form

The following is confidential questionnaire, which will help us determine the best possible course of treatment for you. Please take your time and complete this information accurately. Thank you!

Full Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip Code:_____

Phone #:_____ OK to leave 'medical' message? Yes No Occupation:_____

Age:_____ Date of Birth:_____ Gender:_____ Marital Status (circle one): S M D W

E-mail for medical/healthcare correspondence:_____

Referred to this clinic by:_____

Emergency Contact Information

Name:_____ Relationship: _____Phone Number:_____

I give my consent for Hypo2 High Performance Sport Center to contact the above person in case of an emergency.

Signature :_____ Date:_____

Insurance Information

Our office is not contracted with any insurance companies. If your insurance company cover our service, we are billed under your out-of-network benefits. We will provide you with a 'superbill' to submit to your insurances out-of-network benefits.

Who are we billing? □ Personal Insurance □ Auto Insurance □Workers' Compensation □ Self Pay

Primary Insurance Company Name: _____ Phone # (back of card): _____

Policy/ID #/Claim #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

Current Condition

What symptom(s) are you experiencing:

_____

_____

_____

What caused your symptoms? _____

What date did your symptoms begin? _____

What makes it better? _____

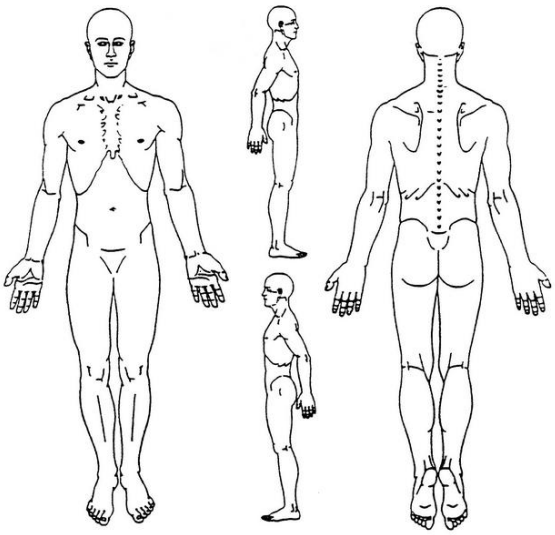
What makes it worse? _____

Are symptoms getting better or worse?_____

Rate your pain on the scale below (circle)

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable)

Please mark areas of pain, tightness or symptoms



Describe your pain (circle): Sharp Dull Burning Electrical Throbbing Constant Intermittent

Does your condition become worse at certain times of the day? Morning Afternoon Night

Interfere with your work duties? Yes No

Interfere with your ability to sleep? Yes No

Interfere with your daily routine? Yes No

Have you had this problem in the past? If so, how often?

_____

Please list any doctor(s) you have seen regarding your condition:

_____

Please list any home care/exercises/remedies you have tried to help improve your condition:

_____

What are your major goals for the first visit? Please tell me what you would like to accomplish on the first visit.

_____

What questions do you have for today's visit?

_____

Health History

PAST MEDICAL HISTORY (Circle all that apply)						
Neuro	Migraine	Tingling feet/hands	Seizures	Shingles	Sciatica	Stroke
Endocrine	Diabetes	Hepatitis	Menopause	High cholesterol	Obesity	
Respiratory	Asthma	Emphysema	Pneumonia	Seasonal allergy	TB	Sinusitis
Cardiac	Heart attack	High blood pressure	Murmur	Arrhythmia	Stent	Valve disorder
GI	GERD	Hemorrhoids	IBS	Gluten sensitivity	Constipation	Gallstones
Vascular	Blood clots	Atherosclerosis	Embolism	Aneurysm	Anemia	Dizziness
Ortho	Osteoarthritis	Fibromyalgia	Osteoporosis	Gout	Hernia	Disc injury
GU	Kidney stones	Bladder infections	Nephritis	Menstrual disorder	Prostatitis	STD
Psych	Depression	Anxiety	Panic	OCD	Bipolar	Addiction
Immune	Rheumatoid	HIV	Thyroiditis	MS	Psoriasis	AS
Cancer	Type and treatment?					
Other	Any other conditions not mentioned?					

Prior Surgeries (List dates for each):

_____ Date_____ _____ Date_____

_____ Date_____ _____ Date_____

Current Medications & Supplements

_____

_____

Please list all food, environmental, and/or drug allergies:

_____

_____

Family Health History: Please list any known cancers, causes of death, immune disorders, heart disease, ect:

Parents:_____ Grandparents: _____

Aunts/Uncles:_____ Grandparents: _____

Brothers/Sisters:_____ Grandparents: _____

Do you currently use any tobacco products? o Yes o No _____pack/day _____ years

Financial Policy Agreement

Cancellation & Missed Appointment Fees

Appointments scheduled represent time specifically set aside for you as a patient. A 24-hour business day notice is required for appointment cancellations. For Saturday, Sunday and Monday appointments, cancellation must occur prior to the preceding Friday at noon. If we do not receive a 24-hour business day notice, you will be charged a $50 appointment cancellation fee. A $50 charge will be billed for all missed appointments. Patients who cancel or no show on three separate occasions will automatically discharged from patient care and will not be able to return to Hypo2 Chiropractic for care in the future.

Please **thoroughly read through the details of the method of payment that applies to you**, sign that you have read and agree to abide by the financial policy as listed below.

Private Insurance

Hypo2 Chiropractic is an out of network provider and therefore does not participate with insurance companies. It is the responsibility of patients interested in seeking care from Hypo2 Chiropractic to ascertain their outpatient chiropractic benefits prior to receiving treatment. Hypo2 Chiropractic will provide every patient with an itemized receipt that can be submitted to your insurance company for reimbursement provided that you have out of network benefits, have met the deductible that corresponds with your plan, and have not exceeded your benefits for the calendar year set forth by your insurance provider. Patients receiving chiropractic care at Hypo2 Chiropractic are expected to pay at the conclusion of each individual treatment session even if we are billing your insurer. To help you determine your benefits we have provided an insurance worksheet under the "Appointments" tab of our website.

- Verification of benefits is not a guarantee of payment by your insurance company.
- Any services not covered by your insurance plan are your responsibility.
- Some insurance plans have a separate benefit for each treatment code billed. It is YOUR responsibility to know your covered benefits.

Self Pay/Not Billing Insurance

Payment is expected at the time services are rendered. Cash, checks and credit cards are accepted for payment.

Auto Insurance

You must notify your insurance carrier of the accident and file a Personal Injury Protection (PIP) form with them. We will bill your auto insurance company. In the event the auto insurance check is sent to you, you are expected to bring the check to our office to be applied to your account. If for any reason your claim is denied or not paid in full by your insurance company, you will be responsible for your bill.

Workers' Compensation

You must report your injury to your employer and fill out an injury report form (801) at your place of employment. We will bill your Workers' Compensation carrier. If for any reason your claim is denied or not paid in full, you will be responsible for your bill.

I authorize my insurance company to make payment directly to this clinic for services rendered and permit this clinic to endorse co-issued remittances for the conveyance of credit to my account. **I understand this clinic will prepare any medical records, necessary forms and reports to assist me in making collection from my insurance company and that any amount paid directly to this clinic will be credited to my account upon receipt.** However, I clearly understand and agree that all services rendered are charged to me directly and that I am ultimately personally responsible for full payment. I agree to pay any costs or fees incurred in connection with the collection of my account, including attorney fees and court costs. I have read, understand and agree to abide by the above financial policy that applies to me, including the Cancellation & Missed Appointment policy.

Signature: _____ Date: _____

Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, manipulations, soft tissue treatment, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Wes Gregg DC or Dr. AJ Gregg, DC, MS, CSCS.

I understand I will have an opportunity to discuss the nature and purpose of chiropractic treatment and procedures with Dr. Gregg during the exam where procedures, alternatives, risks and questions will be answered.

Each procedure and/or treatment carries both risks and benefits. There may be additional or alternative treatments available. Your plan will be researched and customized to your specific needs and goals. No guarantees can be assured regarding the outcomes of treatment(s) or procedure(s). I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, soreness, bruising, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

You are encouraged to ask questions on any health-related topic and to take an active role in your health-care. Our philosophy is a team approach where other doctors play important roles in your health. Our treatment may involve encouraging you to make changes in your diet and lifestyle that can help you attain your highest level of health, fitness and performance.

Information revealed during treatment sessions and office visits/consultations is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to or unless the law authorizes or compels us to do so. Dr. Gregg is happy to work with your other healthcare providers; communication between physicians regarding the health of a patient does not require consent by the patient.

Patients have the responsibility to take treatments as directed and to follow-up as needed.

Name of Patient (Please Print):

_____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Acknowledgement and Consent

I understand that Hypo2 Chiropractic will use and disclose health information about me.

I understand that my health information may include information created and received by Hypo2 Chiropractic, may be in the form of written or electronic records and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that Hypo2 Chiropractic may use and disclose my health information in order to:
• Make decisions about and plan for my care and treatment.
• Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
• Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
• Perform various office, administrative and business functions that support my physician's efforts to provide me with cost-effective health care.

Notice of Privacy Practices describes my rights regarding my health information and the uses and disclosures of health information and the protocol followed by the providers and staff of Hypo2 Chiropractic. I understand that a copy or a summary of the most current version of Hypo2 Chiropractic's Notice of Privacy Practices will be in the waiting/reception area and online. I have read and fully understand Hypo2 Chiropractic's Notice of Privacy practices.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Hypo2 Chiropractic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By:_____ Date: _____
(Patient)

OR

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

Communication Policy

Disclosure Regarding Third-Party Access to Communication

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

Your email will not be sold or shared. This is a HIPPA compliant form required in order to allow correspondence between you and your healthcare provider, as well as our staff and billing department, if you so choose. Here are some examples of email correspondence:

- Receive exercises from your chiropractor.
- Request supplements from your provider.
- Receive notifications from your provider upon supplement shipment arrival.
- Correspond with our billing department.
- Appointment reminders, if that is the method of reminder you have chosen.

Risks and Conditions of Using Email

I have been advised that:

- Email is never appropriate for urgent or emergency problems.
- Emails should not be used to communicate sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, substance abuse, etc.
- All email correspondence will become a part of my health record. It is extremely important to include name and date of birth on each and every email to my healthcare provider. Since email may not be monitored while my healthcare provider is away on business or vacation, I will follow up by telephone or in person if I don't receive a response within a reasonable amount of time.
- Email is not confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their systems.
- There is not a way to assure the privacy of email on a shared computer or email account.
- Email communications travel across the public Internet. It is not possible to verify that email is actually received, opened and read by the addressee.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email as a non-secure form of communication between Hypo2 Chiropractic and myself. I understand that I may revoke this agreement at any time by contacting Hypo2 Chiropractic in writing.

Signature: _____ Date: _____

Name (Printed): _____