CHIROFIT™

NEW PATIENT COVER SHEET

INFORMATION:

PATIENT NAME: _____ DATE: _____

OFFICE LOCATION: _____

☐ AZMEDINJURY ☐ CHIROPRACTIC

CHECKLIST:

- ☐ DATE OF INJURY _____
- ☐ PATIENT ZIP CODE _____
- ☐ PATIENT PHONE _____
- ☐ PATIENT EMAIL _____
- ☐ ATTORNEY INFO / 3RD PARTY INFO _____
- ☐ ALREADY SEEN WITH/WHERE _____
- WORKERS COMP CASE ☐ YES ☐ NO

IF YES, PROVIDE THE FOLLOWING INFORMATION

CLAIM NUMBER: _____

INSURANCE: _____

ADJUSTER'S NAME: _____

CHIROFIT™

PATIENT INTAKE FORM

Office Location_____

Name: _____ Age: _____ Date of birth: _____ Date: _____
Nombre **LAST** **FIRST** **MIDDLE** *Edad* *Fecha de Nacimiento* *Fecha*

Address: _____ Social Security #: _____ ☐ Male ☐ Female
Domicilio *Número de Seguro Social* *Sexo*

City, State, Zip: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____
Ciudad, Estado, Codigo Postal *Estado Civil* *# de Ninos*

Cell Phone (____)_____ Work Phone (_____) _____ Email address: _____
Número de Teléfono Móvil *Número de Teléfono Trabajo* *Correo Electrónico*

Employer: _____ Spouse's Name: _____
Empleadores *Esposa/o*

Occupation: _____ Spouse's Employer: _____
Ocupación *Empleador del cónyuge*

In case of emergency, notify_____ Relationship: _____ Phone (_____) _____
Contacto de Emergencia *Relación* *Telefono*

Current Symptoms: 1. _____ 2._____ 3._____ 4._____
Síntomas
5. _____ 6. _____ 7. _____ 8. _____

For each symptom above, rate on a pain scale (1-10)/ Scala de Dolor (1-10) **Example: neck pain/ 8**

When did your symptoms begin? _____
¿Cuándo comenzó sus síntomas?

In general, what makes your symptoms better? _____
¿En general lo que hace que los síntomas mejor?

In general, what makes your symptoms worse? _____
En general ¿Qué hace que sus síntomas empeoren?

In general, how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____
En general ¿cómo describiría el dolor? (dolor, quemadura, embotado, agudo, pulsátil)

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____
¿Son los síntomas locales o viajan a otra zona? (Si llegan, a donde?)

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**
Son síntomas; ☐*Constante > 76%* ☐*Frecuencia 51-75%* ☐*Ocasional 26-50%* ☐*Intermitente < 25%* ***de sus horas de vigilia***

CHIROFIT™

PATIENT INTAKE FORM

Office Location_____

Chief Complaints/Symptoms:

****Since the accident/injury**, tell me **ALL** symptoms or injuries you have experienced and specifically when each began (write date next to symptom):
*****Desde el accidente**, dígame **TODOS** los síntomas o lesiones que usted ha experimentado y, específicamente cuando comenzaron (Escriba el dia de la fecha junto al síntoma):*

☐ Headache
Dolor de Cabeza

☐ Middle Back Pain/Stiffness
Dolor en medio de la espalda

☐ Ears Ring
Oídos sonando

☐ Any Burns
Quemaduras

☐ Neck Pain/ Stiffness
Dolor en el cuello/ Rigidez

☐ Chest/Chest wall Pain
Dolor en el pecho

☐ Buzzing in Ears
Zumbido en los oídos

☐ Fainting
Desfallecimiento

☐ Dizziness
Mareo

☐ Any Cuts/stitches
Cortadas/Puntadas

☐ Muscle Spasms
Engarrotamiento Muscular

☐ Anxiety
Hacienda

☐ Sleeping Problems
Problemas para dormir

☐ Bruising Anywhere
Hematoma en cualquier lugar

☐ Tingling in Legs
Hormigueo en las piernas

☐ Depression
Depresión

☐ Blurred Vision
Visión Borrosa

☐ Tingling in Arms
Cosquilleo en brazos

☐ Upper/ Lower Leg
Dolor en la pierna superior/ parte baja de la pierna)

☐ Lower Back Pain/ Stiffness
Dolor en la parte baja de la espalda/Rigidez

☐ Sensitivity to Light
Sensibilidad a la luz

☐ Jaw Pain
Dolor de mandíbula

☐ Upper/ Lower Arm Pain
Dolor de brazo superior/ el brazo inferior

☐ Other Symptoms / *Outros Sin Tomas:*

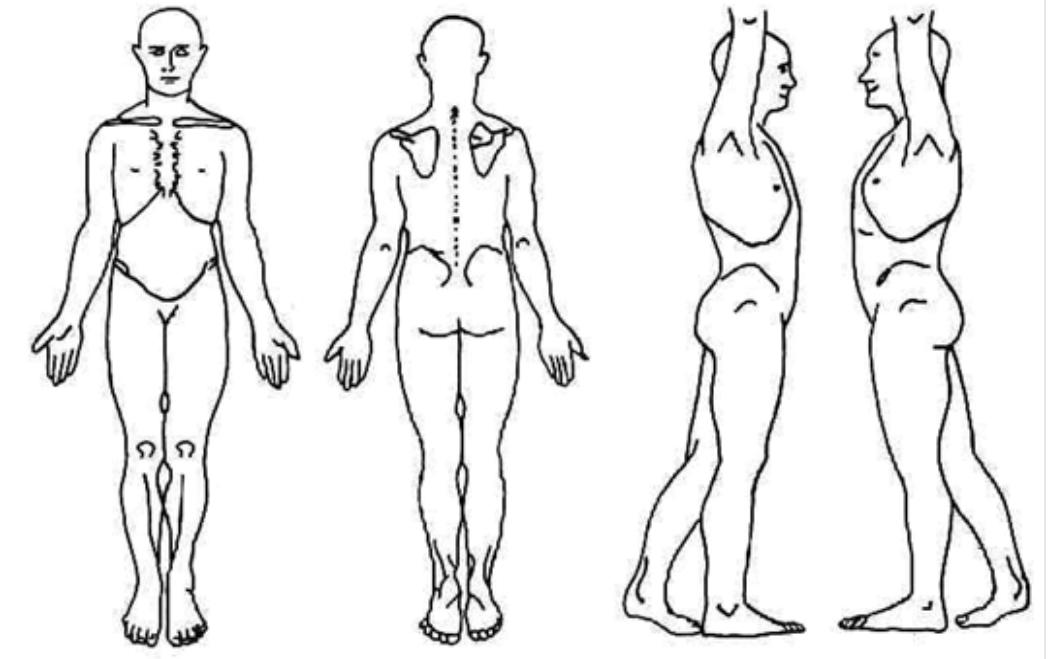
_____

_____

_____

Pain/Symptoms: On the Body Diagram below, indicate your region of pain using the symbols below:

(X) Sharp – *Agudo*
(+) Numb/Tingling – *Entumecido/Hormigueo*
(#) Dull/Aching – *Dolorido*
(B) Burning – *Ardor*



CHIROFIT

PATIENT INTAKE FORM

Office Location_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:
¿TIENES UNA HISTORIA DE CUALQUIERA DE LAS SIGUIENTES ENFERMEDADES?

Tuberculosis ☐ Yes *Tuberculosis*	Lung Disease ☐ Yes *la enfermedad pulmonar*	Gout ☐ Yes *Gota*	Diabetes ☐ Yes *Diabetes*
Kidney Disease ☐ Yes *Enfermedad del riñón*	Stomach/Ulcer ☐ Yes *Sí la úlcera de estómago*	Heart Disease ☐ Yes *La enfermedad cardíaca*	Hepatitis ☐ Yes *Hepatitis*
Sciatica ☐ Yes *Ciática*	Blood Pressure ☐ Yes *La presión arterial*	Transfusion ☐ Yes *La transfusión*	Polio / MS ☐ Yes *La poliomielitis / MS*
Colon Disease ☐ Yes *Enfermedad de colon*	Stroke ☐ Yes *Movimiento*	Cancer ☐ Yes *El cáncer*	Bleeding ☐ Yes *Sangrado*
Paralysis ☐ Yes *Parálisis*	Seizures ☐ Yes *Las convulsiones*	Arthritis ☐ Yes *La artritis*	Asthma ☐ Yes *Asma*
Anemia ☐ Yes *Anemia*	Thyroid Disease ☐ Yes *La enfermedad de tiroides*	Drug Dependence ☐ Yes *La droga dependencia*	AIDS ☐ Yes *SIDA*

Were there any symptoms which you had after the accident/injury that have now resolved? (please list)
¿Donde hay algún síntoma que había tras el accidente que ahora ha resuelto? (por favor, lista)

_____

Please list all medications and dosage: **Frequency?** **For What Illness?**
Por favor una lista de todos los medicamentos y dosis: Frecuencia para qué enfermedad?

_____

_____

List any allergies to medications, foods or other: _____
Lista de alergias a medicamentos, alimentos u otro

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____
Está embarazada *Primer día del último ciclo menstrual*

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____
¿Usted fuma? *¿Usted bebe alcohol?* *¿Cuánto?*

Please list all serious illness: **Month and Year** *(Mes y año)*
Por favor una lista de todas las enfermedades graves

_____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**
Por favor indique cualquier radiografías recientes, laboratorio u otros exámenes *Fecha* *Servicio/médico*

_____

_____

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

Date of current accident/injury ***(Fecha de accidente actual)*****:** _____**Hour:** _____**AM** _____**PM** _____

Specific Location of accident ***(Ubicación específica del accidente)***:_____

City ***(Ciudad)*** _____**County** ***(Condado de)***_____

Describe in detail, in your own words, how the accident/injury happened: _____
Describir en detalle, en sus propias palabras, cómo sucedió el accidente

_____

_____

AUTOMOBILE/MOTORCYCLE ONLY

In the accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____
En el accidente: Eras el ☐ Controlador ☐ Pasajeros ☐ Peatonal

Did your vehicle strike the other vehicle? ☐ Yes ☐ No
¿Su vehículo huelga el otro vehículo? ☐ Si ☐ No

Did the other vehicle strike your car? ☐ Yes ☐ No
¿Hizo el otro vehículo golpear su coche? ☐ Si ☐ No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐ Left Side ☐ Right Side
Pulsaron de? ☐ Detrás de ☐ Delantero ☐ Del lado del conductor ☐ Lado del pasajero ☐ Lado izquierdo ☐ Lado derecho

Did airbags deploy? ☐ Yes ☐ No
Se abrio la bolsa de segurida de aire? ☐ Si ☐ No

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given
Se expidieron citaciones de tráfico a? ☐ Se ☐ Conductor de su vehículo ☐ Conductor del otro vehículo ☐ No hay citaciones dado

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)
Fue el rumbo del vehículo?

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)
Fue el otro epígrafe?

Have you lost time from work? ☐ Yes ☐ No:
Han perdido tiempo de trabajo? ☐ Sí ☐ No:

If Yes, Dates: _____ to _____
En Caso Afirmativo, Fechas: _____ *a* _____

Where did you go after the accident? ☐ Hospital ☐Urgent Care ☐ Home ☐ Work ☐ Other _____
*Donde ir después del accidente? ☐ Hospital ☐ Urgencias ☐ Inicio ☐ Trabajo ☐ Otros*_____

Were you taken by ambulance? ☐ Yes ☐ No
Fue tomado por ambulancia?

To which hospital? _____
A qué hospital?

Address: _____
Dirección

Date of Hospitalization: _____
Fecha de hospitalización

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____
SU COMPAÑÍA DE SEGUROS DE AUTOMÓVIL

Address: _____ Telephone: (_____)_____ Fax: (_____)_____
Domicilio *Número de Teléfono*

Claim #: _____ Policy #: _____ Claim Rep: _____
Número de Reclamo *Número de Póliza* *Representante de*

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure
Ha firmado una renuncia de la selección de beneficios? ☐ Sí ☐ No ☐ No está seguro

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No
Eres un estudiante a tiempo completo? ☐ Sí ☐ No no vive con un pariente? ☐ Sí ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____
SU COMPAÑÍA DE SEGUROS DE SALUD

Address: _____ Insured: _____
Domicilio *Asegurado*

Date of Birth: _____ Policy #: _____ SS#: _____
Fecha de Nacimiento *Número de Póliza* *Número de Seguro Social*

Telephone: (_____) _____ Fax: (_____) _____
Número de Teléfono

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (_____)_____ Fax: (_____)_____
Domicilio *Número de Teléfono*

Claim #: _____ Policy #: _____ Claim Rep: _____
Número de Reclamo *Número de Póliza* *Representante de Reclamaciones*

4) ATTORNEY: _____ Legal Assistant: _____
Abogado *Asistente Legal*

Address:_____
Domicilio

Telephone: (_____) _____ Fax: (_____) _____
Número de Teléfono

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

FOR AUTO INJURY PATIENTS ONLY AND DOCTOR'S LIEN

Dear Patient:
It has become standard practice in the Health Care Industry and a requirement of the State of Arizona per Statute 33-931 and 33-932 to file what is known as "Notice and Claim of Health Care Provider Lien". These liens must be recorded with the County Recorder's Office, by law. A copy will be sent to you by certified mail for your records, and will be released when we receive payment in full. A copy of the release will also be sent to you via first class mail.

Please be assured that this is not a lien against you, or your property. This is not a reflection on your integrity and will not be picked up by credit reporting agencies for any reason, as this lien is not against you the patient, but merely a lien for payment from the responsible insurance company for your medical care costs.

At the time of settlement of your case you will receive a check/draft made out jointly to you and the Doctor, at which time you are required to promptly bring the check/draft to our office for disbursement of funds.

If you have an attorney, the check will be made out to you and your attorney. Your attorney must sign an indemnifying agreement with the insurance company to pay any and all liens in full. If for some reason your settlement does not cover the cost of your care, you are personally responsible and agree to pay the balance of the bill in full.

By signing this notice you understand and agree to the above terms.

Patient Name:_____

Attorney: _____

Date of Injury: ____/____/_____

I hereby authorize and irrevocably direct my attorney, _____, to pay promptly to CHIROFIT Chiropractic and Physical Therapy and Arizona Medical & Injury, PLLC, from my portion of any proceeds out of any recovery relevant to the action in which he represents me.

Dated: ____/____/____ Signature: _____
Patient/Debtor

The undersigned being the attorney of record for_____
Does hereby agree to observe all the terms of the above and agrees to withhold such sums from settlement, judgement, or verdict as may be necessary to adequately protect CHIROFIT Chiropractic and Physical Therapy and Arizona Medical & Injury, PLLC, and/or their assignor.

Dated: ____/____/____ Signature: _____
Attorney

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

AUTHORIZATION TO REQUEST (AND RELEASE WHEN NECESSARY) MEDICAL RECORDS

Fax#_____

Patient Name_____

D.O.B_____

Date of Injury_____

I hereby authorize _____to release any information including the intake sheets, diagnosis, labs, x-rays, and records of any treatment rendered to me at this facility.

I also hereby authorize the release TO any appropriate attorney's office and/or healthcare provider to which I may need to be referred to for treatment as a result of this accident.

Additionally, I authorize the release to any medical provider who rendered treatment to me at this facility and who may be called upon to discuss my injuries and the treatment rendered therefor.

This consent expires 24 months after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify ARIZONA MEDICAL & INJURY/ CHIROFIT in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____

PATIENT SIGNATURE Date:

PLEASE FAX REQUEST TO 623-776-2813 ASAP

Office Location_____

ACKNOWLEDGEMENT OF OWNERSHIP / ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

I hereby acknowledge that by signing this Acknowledgement of Ownership I fully understand that Dr. Scott Stamp DC has ownership interest in CHIROFIT and Arizona Medical & Injury, PLLC and will financially benefit from the procedures being performed on this date.

Should I elect not to accept a referral from one entity to the other, I am hereby informed and understand that I may choose another facility within which I can receive medical services.

I authorize all insurance benefits, unless previously paid by myself, to be paid directly to CHIROFIT and Arizona Medical & Injury, also authorize the release of all information required in the processing of the insurance claim submitted on my behalf. I further authorize the release of any and all medical information deemed necessary for my health care to my referring physician, primary care physician, spouse, children, parents, physician and attorney deemed necessary.

NOTE: If you do not understand any part of this document, please speak to a staff member before signing.

_____ _____

PATIENT SIGNATURE (or Parent of Minor) Date:

AUTHORIZATION TO BILL HEALTH INSURANCE

I (Patient Name) _____

_____ Give Authorization

_____ Do NOT Give Authorization

To Arizona Medical and Injury / CHIROFIT to bill my health insurance for my care related to my injury on (date) _____.

Patient Signature: _____ Date: _____

CHIROFIT

PATIENT INTAKE FORM

Office Location_____

Informed Consent to Chiropractic/Medical Treatment/HIPPA/Assignment of Benefits

This form contains how your Patient Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

Initial_____

1. The patient understands and agrees to allow CHIROFIT Chiropractic and Physical Therapy (CHIROFIT) and Arizona Medical & Injury (AZ Med) to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to exam and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained on time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CHIROFIT to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

Authorization, Assignments of Benefits and Consent to Treat

To: CHIROFIT and AZ Med Doctors, hereafter refer to as OFFICE:

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as maybe due and owing the OFFICE, of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and it may be necessary for the OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary the OFFICE may employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a massage appointment 24 hours in advance of the appointment I may be charged a $25.00 cancellation fee.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment and/or insurance issues.
7. I give permission to the office to send me birthday cards, holiday-related cards, thank you cards and gifts. Call me and/or leave me messages for me on an answering machine. Provide me information on treatment and other health related information. Allow staff and other patients to view my name on the sign in register. Treat me in a semi-open room where others may see me if passing by in the hall.
8. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment and diagnosis x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who know or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
9. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, as in my best interest.
10. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about it, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) I seek treatment.
11. A photocopy of this form shall be valid as original.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient/Guardian if Patient Minor Date