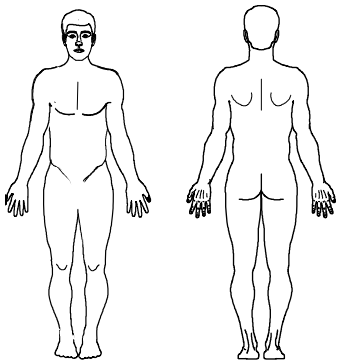
☐ Douglas S. Wilson, DC, INC ☐ James E. Peterson, DC
2615 South Miller Street, STE 108
Santa Maria, CA 93455

Chiropractic Wellness Group
Initial Health Status

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ e-Mail Address: _____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

CHIROPRACTIC WELLNESS GROUP
JAMES E. PETERSON, DC
DOUGLAS S. WILSON, DC

PATIENT NAME: _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICE

I understand that under the "Health Insurance Portability & Accountability Act of 1996" (HIPAA), that I have certain rights to privacy regarding my protected health information (PHI). **I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and/or indirectly; 2) Obtain Payment from third party payers; 3) Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have been informed and had access to Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Chiropractic Wellness Group has the right to change their Notice of Privacy Practices from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____
Patient Signature (or responsible party if patient is a minor) Date

FINANCIALLY RESPONSIBLE PARTY

Name: _____
LAST FIRST MIDDLE

Address: _____ City: _____ Zip:_____

Telephone: _____ Cellular: _____ Work: _____

Date of Birth: _____ Relationship to Patient: _____ Drivers Lic#: _____

Social Security # (SSN): _____ - _____ - _____ Employer: _____

SIGNATURE ON FILE/INFORMATION RELEASE AUTHORIZATION

By my signature below I authorize Chiropractic Wellness Group to release the necessary health information concerning my diagnosis and treatment for the purpose of securing payment from my insurance company and hereby authorize payment of the insurance benefits directly to the doctor for services rendered that are not paid for directly by me *(Insurance payers only, not Medicare)*. I permit a copy of this authorization to be used in place of the original.

_____ _____
Patient Signature (or responsible party if patient is a minor) Date

CHIROPRACTIC WELLNESS GROUP
JAMES E. PETERSON, DC
DOUGLAS S. WILSON, DC

OUR FINANCIAL POLICY

We welcome you to our office. Your health is our chief concern and we strive for excellence in chiropractic care. In order to make the handling of your financial obligations as smooth as possible, please read and sign the following policy. If you have any questions, our staff will be happy to assist you.

General Insurance Information

Please remember that all health and accident policies are arrangements between you and the company that writes the policy. All charges in this office are your personal responsibility and all fees are charged directly to you. As a courtesy to you, we will prepare necessary insurance claim forms to assist in collections from your insurance company. We will also bill insurance on your behalf and will expect payment from them within 60 days. Should the claim remain unpaid over 60 days for any reason, we will then personally bill you for the balance, net 30 days. Please note that this office will not enter into dispute with an insurance company over your claim.

Your coverage (PPO, HMO, EPO, HSA, etc.)

This office in under contract with many insurance plans. Please present your insurance card to the front desk so that we may make a copy for the file. On your behalf, we will immediately begin verifying your exact coverage. You will need to sign the Signature on File/Authorization form. Your financial obligation may consist of a co-payment and/or a deductible. The co-payment will be either a fixed amount or a percentage of the charges. Co-payments vary from plan to plan but generally range from $5.00 to $30.00 per visit. Please note that **deductibles and co-payments are due at the time of visit**.

Worker's Compensation

With authorization to treat from your employer, if you are hurt on the job your care is handled 100% through eligible worker's compensation benefits.

Personal Injury

This category also includes automobile accidents. If you have medical coverage (med-pay) on your auto insurance policy, we will bill them directly for prompt payment of your care. This coverage is in place to immediately handle your medical needs regardless of who is at fault. If you are not at fault, you will not be penalized by your insurance company as they will collect for reimbursement from the responsible party. If med-pay is not part of your coverage, we will set up monthly payment arrangements. Please remember, you are directly responsible for payment of your bill.

Medicare

We are happy to accept Medicare patients; however we do not accept Medicare assignment. Therefore, all charges incurred will be your responsibility and Medicare will reimburse you. You will receive our MEDICARE INFORMATION AND PAYMENT POLICY. Please read and sign this form. We will be happy to answer any questions.

Personal Pay/Cash

Because of decreased administrative costs, we are able to extend a cash discount to our cash paying patients. Cash accounts are payable at time of visit and will not be billed unless arrangements have been made with our office manager.

No Show Policy

It is important to our patients that we stay on schedule and make ourselves available to those patients in need with minimal or no wait time. To make this happen, we work hard to keep on schedule and many times have a waiting list for patients needing care. If you must cancel an appointment, we understand that things come up. A courtesy phone call is of paramount importance. A "no-show" takes an opportunity away from another patient who may be at home waiting on a call from us. To that end, our office has implemented a "no-show" fee of $40.00 which will be paid in full prior to the next scheduled visit.

♦ ♦ ♦

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY CONCERNING PAYMENT/POLICIES IN THIS OFFICE.

_____ _____

Patient's Signature Date