Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926

Confidential Patient Information

Full Name:_____ Date of Birth__/___/___ Age:____

Address:_____City_____ State_____ Zip_____

Mailing Address:_____City_____ State_____ Zip_____

SSN:_____-_____-_____ Home Phone: (___)_____ Cell Phone(___)_____

Marital Status (_) Married (_) Single (_) Widowed (_) Divorced (_)Partnered for __ years

Date Symptoms Began:_____/_____/_____

Employer's Name:_____ Occupation:_____

Work Address:_____ City_____ State_____

Work Phone Number (___)_____ Ext_____

Emergency Contact Name & Relationship:_____

Phone Number: (_____)_____

Authorizations:

A. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts payment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient / Guardian Signature:_____

Date:_____

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926

Informed Consent For Chiropractic Care

I hear by request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Laufer and/or with office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignment and such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise , of a cure for any symptom, disease or condition as a result of treatment in this clinic office. I understand that the chiropractor will use her/his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop"or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during the examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature:_____Date:_____

Phone:(530)895-1151 Fax: (530)895-1147 lauferchiropractic@yahoo.com lauferchiro.com

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926
530.895.1151

Authorization and Consent Applied Kinesiology

During your course of care at Laufer Chiropractic, one of the techniques used will be Applied Kinesiology. This is a technique of muscle testing. Various muscle groups are evaluated to determine their strengths or weaknesses relative to the physical and postural problem you have at the time you enter the office.

Research done by Dr. George Goodheart has shown that there are five factors that can affect the muscle function. They are classified as : Nerve Supply, Neurolymphatic, Neuromuscular, Meridian, or Nutritional. They are often treated by stimulation, by hand or finger, on specific points on the body. There is a chart in each treatment room that depicts the location of these various points. Some of these areas may be considered sensitive i.e. the pubic area or the breast area. These procedures are done while the patient is fully clothed. The doctor will review the weakness in your particular case. If a sensitive area is involved you will be told before any procedure begins.

I have read this authorization and discussed Applied Kinesiology with Dr. Alex Laufer or his staff.
I do consent to have this form of therapy used on me during the course of care for my current condition and any future conditions that I may have treated at Laufer Chiropractic.

Print Name:_____Date:_____

Signature:_____ Date_____

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926
530.895.1151

Cancellation Policy

In an effort to serve you and our other patients more effectively, our office will be strictly enforcing our office cancelation policy.

A charge of $15.00 will be charged to your account for all missed appointments without at least 24 hours prior notification.

Should you have questions about this policy, please address your concerns to our front desk staff.

I have read and understand this policy.

Name:_____

Signature:_____

Date:_____

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926

Explanation of Medicare Benefits to the Patient

Medicare will review all services after the first visit of that year for medical necessity to determine further coverage. Medicare will cover Chiropractic office visits after your yearly deductible has been met.

Services **NOT** covered by Medicare include: **Cervical pillows, supplements, and orthotic supports**. Therefore, **YOU** will be responsible for payment in full for these services and they WILL NOT be applied toward your deductible. Deductibles start again at the beginning of every year.

Each year Medicare decides how much they are willing to allow for chiropractic services. Currently, they are allowing $ 42.19. Our fee is slightly higher, so we adjust off the difference. If you have not yet met your deductible, you will be paying $42.19 per visit. Once your deductible is met , Medicare will pay 80% of the allowable amount: $33.76. The remaining 20% ($8.43) is your responsibility. If you have a secondary/supplemental insurance, it normally picks this portion up.

Examples: **Once you have met your Deductible**

Billed :	$48.00
Medicare Allows:	$42.00
Difference:	$6.00 (we adjust off , eliminating it from your bill)
Medicare pays 80%	33.60
Remaining:	**$8.40 (This is what you pay or is sent to secondary)**

This only pertains to the allowed visits. Medicare will only pay for a certain number of visits, depending on your condition. Any visit after the allowable amount has been reached, will be your responsibility.

We do accept assignment, which means that Medicare will send their check directly to us in payment of services that they cover in our office. We will bill Medicare twice a month for you. Medicare will then forward all bills to your secondary insurance, if you have supplied them with the policy information.

Upon my signature on the EXPLANATION OF MEDICARE BENEFITS TO THE PATIENT, I attest that I have read and understand these benefits.

Signature :_____**Date:**_____

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926

Cash Payment Policy

This letter is written to familiarize you with the payment policy for our chiropractic office.

Payment is due in full at the end of each visit, unless a payment plan has been previously established.

Please sign and date below if you have read and understand this policy.

Printed Name:_____Date:_____

Patient Signature:_____

Laufer Chiropractic
A Family Wellness Center
1810 Esplanade, Suite A
Chico, CA 95926
530.895.1151

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for Laufer Chiropractic, detailing how my information may be used and disclosed as permitted under federal and state law.

.

Name:_____

Signature:_____

Date:_____

HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ● . **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Date Of Birth

Social Security #

Sex: ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Other

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Referred By

Spouse Name

Social Security #

Patient Resides With: ○ Lives Alone ○ Spouse ○ Parents ○ Children ○ Other

Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

A. MAJOR COMPLAINTS

1. What are your major complaints?

○ None	Pain	Numbness	Tingling
Head	(H)	(H)	(H)
Neck	(N)	(N)	(N)
Upper Back	(U)	(U)	(U)
Mid Back	(M)	(M)	(M)
Lower Back	(L)	(L)	(L)

	Pain R	Pain L	Numbness R	Numbness L	Tingling R	Tingling L
Shoulder	(S)	(S)	(S)	(S)	(S)	(S)
Arm	(A)	(A)	(A)	(A)	(A)	(A)
Forearm	(F)	(F)	(F)	(F)	(F)	(F)
Hand	(H)	(H)	(H)	(H)	(H)	(H)
Buttock	(B)	(B)	(B)	(B)	(B)	(B)
Hip	(H)	(H)	(H)	(H)	(H)	(H)
Thigh	(T)	(T)	(T)	(T)	(T)	(T)
Leg	(L)	(L)	(L)	(L)	(L)	(L)
Foot	(F)	(F)	(F)	(F)	(F)	(F)

2. Currently your pain is aggravated by

○ Coughing ○ Lifting
○ Sneezing ○ Bending
○ Straining At Stool ○ Sitting
○ Neck Movement ○ Standing
○ Reaching ○ Walking
○ Other

3. Since your symptoms began, have you noticed a change in

○ Bowel Function ○ Bladder Function
○ Ability To Maintain An Erection

B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

1. a. **GENERAL**
○ Normal ○ Chills
○ Fatigue ○ Weight Change
○ Weakness ○ Night Sweats
○ Fever ○ Other

b. **SKIN**
○ Normal ○ Eczema
○ Rash ○ Hair Changes
○ Redness ○ Nail Changes
○ Itching ○ Other

c. **NEUROLOGIC**
○ Normal ○ Fainting
○ Headache ○ Convulsions
○ Dizziness ○ Other

d. **EYES**

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

e. **EARS**

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

f. **NOSE**
○ Normal
○ Pain ○ Absence Of Smell
○ Bleeding ○ Other

g. **MOUTH/THROAT**
○ Normal ○ Absence Of Taste
○ Sores ○ Abnormal Taste
○ Bleeding ○ Other

h. **HEART/LUNGS**
○ Normal ○ Blue Extremities
○ Cough ○ Murmur
○ Wheezing ○ Chest Pain
○ Difficulty Breathing ○ Palpitations
○ Swollen Extremities ○ Other

i. **BREASTS**
○ Normal ○ Dimpling
○ Lumps In Breast(s) ○ Discharge
○ Redness/Itching ○ Other
○ Pain

j. **STOMACH/INTESTINES**
○ Normal ○ Vomiting
○ Decreased Appetite ○ Diarrhea
○ Increased Appetite ○ Constipation
○ Abdominal Pain ○ Other

k. **REPRODUCTIVE/URINATION**
○ Normal ○ Impotence
○ Inability To Hold Urine ○ Sterility
○ Painful Urination ○ Other
○ Frequent Urination
○ Irregular Menstruation
○ Painful Menstruation
○ Abnormal Vaginal Bleeding

l. **GLANDULAR**
○ Normal ○ Goiter
○ Heat/Cold Intolerance ○ Tremor
○ Sugar In Urine ○ Other

m. **MENTAL**
○ Normal ○ Phobias
○ Anxiety ○ Mood Swings
○ Depression ○ Other
○ Memory Loss or Impairment

907592

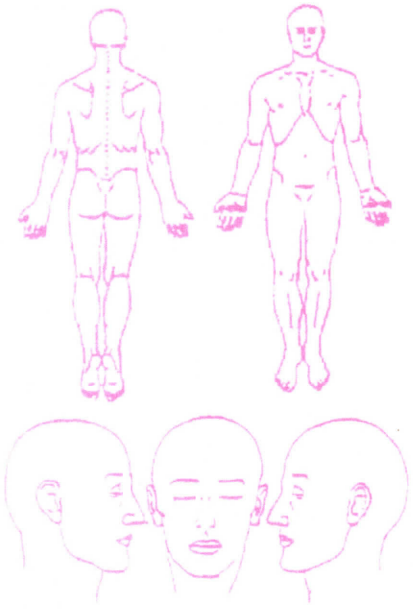
PLEASE MAKE NO MARKS IN THIS AREA

2. What are your habits?

	Never	Occasionally	Moderately	Excessively
Smoking	S	S	S	S
Alcohol	A	A	A	A
Recreational Drugs	R	R	R	R
Exercise	E	E	E	E

C. PAIN DIAGRAMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	Y	N
b. Do you have a family physician	Y	N
c. WOMEN:		
To the best of your knowledge are you pregnant	Y	N
Are you under the regular care of an OB-GYN	Y	N
d. Have you been hospitalized in the past five years	Y	N
e. Are you currently taking any medication	Y	N

- Anti-inflammatory (Aspirin, Motrin, etc.)
- Muscle Relaxants
- Pain Medication/Analgesic
- Tranquilizers
- Birth Control Pills
- Other

2. Which of the following illnesses have you had?

- No Previous Conditions/Illnesses
- Arthritis
- Asthma
- Sinus Trouble
- Hay Fever
- Allergies
- Tuberculosis
- Diabetes
- Epilepsy
- Thyroid Trouble
- High Blood Pressure
- Low Blood Pressure
- Heart Trouble
- HIV/ARC
- AIDS
- Sexually Transmitted Disease
- Ulcer
- Cancer
- Polio
- Rheumatic Fever
- Serious Injury
- Bone Fracture
- Dislocated Joints
- Spinal Disc Disease
- Multiple Sclerosis
- Scoliosis
- Mental/Emotional Difficulty
- Prostate Trouble
- Kidney Trouble
- Other

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Mother	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
Brothers	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
Sisters	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Children	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	Y	N
Date of Accident		
Have You filed an accident report	Y	N
2. Is your condition due to a job injury	Y	N
Date of Injury		
Have You filed an injury report	Y	N
3. Do you have health insurance	Y	N
Company		
Policy #		
4. Are you covered by Medicare	Y	N
Medicare #		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

F. PAYMENT

I WILL BE PAYING TODAY BY:

- Cash
- Check
- Credit Card

- MasterCard
- Visa
- American Express

Account # Exp. Date

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature Date

Guardian or Spouse's Signature Date

Doctor's Signature Date

Printed In The USA (20050802-1305) EW-230058-3:16