

Office Policy



Welcome to Lake Pointe Chiropractic and Wellness

Payment

Payment is due at the time of service. LPCW accepts cash, checks (made payable to LPCW), Visa, and MasterCard.

Insurance

Insurance benefits are not a guarantee of payment by your insurance company. It is your responsibility to notify LPCW immediately if your insurance coverage changes or if you are involved in an automobile or worker's compensation accident. We will submit chiropractic claims for you when warranted. Insurance plans do not cover nutritional consultations, wellness services, supplements, herbs, and other products. Payment for these items is your responsibility and due at the time of service/purchase.

Cancellation Policy

LPCW understands that from time to time there may be conflicts with your schedule. We request that you notify us 24 hours prior to your appointment if you need to cancel or change an appointment. You will be responsible in full for the charges of the appointment with less than 24 hours notice.

Perfumes and Fragrances

Please help those clients with compromised immune systems and sensitivities by not wearing perfumes or fragrances to the office.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

If you would like a complete copy of this explanation, please initial here: _____

Nutrition and Supplement Recommendations

I acknowledge that it is my full responsibility to share my nutritional protocol with medical providers related to my health condition and wellbeing. Please Initial here: _____

Please sign and print your name and provide the date below to acknowledge that you understand and agree to the above Office Policy.

Patient Name: _____

Signature: _____ Date: _____

Patient Information



Patient Name: _____ Today's Date: _____

Date of Birth: _____ Social Sec. #: _____ - _____ - _____

Sex: Male Female Decline to Specify Ethnicity _____

Address: _____

City: _____ State: _____ ZIP _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____ Would you like to be added to our email list? Yes No

Marital Status: Married Widowed Single Divorced Unknown

Occupation: _____ Employer/School: _____

Emergency contact: _____ Relationship to patient: _____

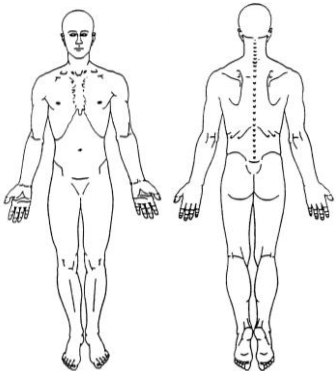
Contact Phone: _____ Alternate Phone: _____

Referred by: _____

Please describe what brings you in today? _____

When did your symptoms first appear? _____

Rate your pain on a scale from 1 (least) to 10 (severe): **1 2 3 4 5 6 7 8 9 10**

<p>Type of Pain</p> <p><input type="checkbox"/> Sharp <input type="checkbox"/> Burning</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Cramps</p> <p><input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Aching <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Other _____</p>	<p>How often do you have this pain?</p> <p><input type="checkbox"/> Constant</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Weekly</p>	<p>Does it interfere with:</p> <p><input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> Standing</p> <p><input type="checkbox"/> Lying Down</p> <p><input type="checkbox"/> Sleep</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Daily Activities</p>	<p>Mark on the picture where you have symptoms</p> 
<p>What treatment have you already received for your condition?</p> <p><input type="checkbox"/> Acupuncture <input type="checkbox"/> Medications <input type="checkbox"/> None</p> <p><input type="checkbox"/> Chiropractic Services <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Massage <input type="checkbox"/> Surgery _____</p>			

Please describe any injuries or surgeries (e.g. slips/falls, head injuries, broken bones, dislocations, surgeries, auto accidents): _____

Would you like to...

<input type="checkbox"/> Have more energy	<input type="checkbox"/> Have stronger nails/ healthier hair	<input type="checkbox"/> Decrease allergies
<input type="checkbox"/> Lose weight	<input type="checkbox"/> Feel less stressed	<input type="checkbox"/> Decrease drugs/ OTC meds
<input type="checkbox"/> Sleep better	<input type="checkbox"/> Get sick less frequently	<input type="checkbox"/> Improve focus/ memory / mood
<input type="checkbox"/> Improve your complexion	<input type="checkbox"/> Improve your digestion	<input type="checkbox"/> Feel fewer aches and pains

Health History



Date of Last: _____
 Physical Exam _____ Spinal X-Ray _____ Blood Test _____ MRI, CT-Scan, Bone Scan _____

Please check box below to indicate if you have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Alcoholism/
Chemical
Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tumors/ Growths |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Decreased Sexual
Drive | <input type="checkbox"/> Pinched Nerve | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Prostate Problem | |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Prosthesis | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Sexually Transmitted
Disease | |
| | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Suicide Attempt | |

WOMEN

Breast Lump

Endometriosis

Fibroids/ Cyst Ovarian

Hormone Imbalances

Hot Flashes

Menopause

Menstrual Cramps

Vaginal Infections

Birth Control
(Current/ Past)
Type: _____

How long? _____

WOMEN

Are you pregnant? Yes No How many weeks? _____ Estimated due date: _____

Home or Hospital birth: _____ Health Care Providers/Birth Team: _____

Symptoms specific to pregnancy? _____

Concerns related to pregnancy, labor and/or delivery/birth? _____

Number of Pregnancies: _____ Abortions: _____ Miscarriages: _____ Children: _____

Family History

	Living: Y/N	Cause of Death	Age	History of Disease?
Mother				
Father				
Grandparents				
Siblings				

Lifestyle Habits



<p>Exercise</p> <input type="checkbox"/> None <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> 3-4 times per week <input type="checkbox"/> 5-6 times per week <input type="checkbox"/> Daily	<p>Work Activity</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>Eating Habits</p> <input type="checkbox"/> Skip Breakfast <input type="checkbox"/> 1 Meal/ Day <input type="checkbox"/> 2 Meals/ Day <input type="checkbox"/> 3 Meals/ Day <input type="checkbox"/> Graze all day <input type="checkbox"/> Generally eat on the run <input type="checkbox"/> Eat constantly whether hungry or not <input type="checkbox"/> Cravings: <input type="checkbox"/> Bread <input type="checkbox"/> Sugar <input type="checkbox"/> Salt <input type="checkbox"/> Alcohol	<p>Habits</p> <input type="checkbox"/> Water: Glasses/ Day: _____ <input type="checkbox"/> Caffeine Drinks: Type (coffee, soda, tea, etc.) _____ Drinks/ Day: _____ <input type="checkbox"/> Alcohol: Drinks/ Day: _____ <input type="checkbox"/> Smoking: Packs/ Day: _____
<p>Bowel Movements</p> <p>I have bowel movements daily: YES / NO</p> <p><u>Consistency:</u></p> <input type="checkbox"/> Diarrhea/ Loose Stools <input type="checkbox"/> Formed <input type="checkbox"/> Constipated			

Sleep

Average hours of sleep per night: _____

How long does it take to fall asleep? _____

How many times do you wake up per night? _____

If you wake, up can you fall back asleep? YES / NO

Do you wake up tired even when you get enough sleep? YES / NO

Stress

Circle the level of stress you experience on the scale of 1-10, 10 being the worst:

1 2 3 4 5 6 7 8 9 10

What do you consider to be the major causes of your stress? (Spouse/family, work, finances):

Allergies

Please list any allergies (including food allergies): _____

I am sensitive to: Perfume Tobacco smoke Chemical smells

Please indicate any medications / supplements currently taking:

Medications	How Long?	Condition it's treating	Supplements	Supplement Brand

Estimated monthly medication/ supplement cost? _____

Are your medications/ supplements working? YES / NO

How do you know? _____

Commitment to Care

Low Commitment Medium Commitment High Commitment Just Don't Know

Verbal Disclosure Form



Patient Name: _____ Date of Birth: _____

I authorize Lake Pointe Chiropractic & Wellness (LPCW) to verbally discuss the following protected health information about me with the individuals listed below (check all boxes that apply):

- Scheduling/appointment information
- Billing/payment information
- Medical information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Behavioral/mental health information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Chemical dependency information including symptoms, diagnosis, treatment plans, medications, and recommendations
- Lab/test results
- Other (please describe): _____

I authorize LPCW to discuss the information selected above with the following individuals:

Name: _____

Name: _____

Name: _____

Name: _____

I understand that I may revoke this authorization at any time, but that it will not affect any disclosures already made under this authorization prior to revocation. I understand that my revocation of this authorization must be presented in writing to LPCW.

Signature of Patient/ Guardian: _____ Date _____