EMPOWER

HEALTH + PERFORMANCE

Patient Information

Name: _____

Last First MI

Mailing Address: _____

Address City State Zip Code

Email Address: _____

Phone #: **(H)** _____ **(W)** _____ **(C)** _____

Date of Birth: _____ **Sex**: ☐ Male ☐Female

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐ Minor

Occupation: _____ **Employer**: _____

Emergency Contact: Name: _____ Relation: _____ Phone #**:** _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No

If yes, what type? ☐ Auto ☐ Work ☐ Other_____ Date of accident: _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to Patient (if other than self): _____ Date of Birth: _____

Employer: _____

Insurance Carrier: _____ Subscriber #: _____

Group Number: _____ Secondary Insurance?: ☐ Yes ☐ No

Patient Health Questionnaire

Patient Name: _____ **Date**: _____

Describe your symptoms: _____

_____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

☐ Intermittently (0-25% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Constantly (76 – 100% of the day)

Describes the nature of your symptoms:

☐ Sharp ☐ Shooting ☐ Dull ache ☐ Burning ☐ Numbness ☐ Tingling ☐ Other: _____

Have your symptoms changed since initial onset? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

During the past 4 weeks: Indicate the average intensity of your symptoms: (circle one)

☐1 ☐ 2 ☐3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

AGGREVATORS: What aggravates your symptoms?		RELIEF: What relieves your symptoms?	
☐Bends ☐Climbs stairs ☐Coughs ☐Drives ☐Goes down stairs ☐Lying on side ☐Stands for too long ☐Is under stress ☐Certain movements ☐Is at work	☐Lifts hands over head ☐Lifts ☐Picks up child ☐Working out ☐Sits ☐Sleeps ☐Travels ☐Turns over in bed ☐Walks ☐Working on the computer ☐Other: _____	☐Adjustments ☐Analgesic cream ☐Exercising ☐Heat ☐Ice ☐Lying on back w/knees bent ☐Lying on your side ☐Massage ☐Muscle Relaxer ☐NSAID/ over the counter meds	☐Prescription Meds ☐Resting ☐Standing ☐Stretching ☐Swimming ☐TENS Unit ☐Tylenol ☐Walking ☐Yoga ☐Kinseo-tape ☐Other: _____

Have you seen any of the following providers for your symptoms?

☐ No One ☐Primary Care Physician ☐Orthopedist ☐ Physical Therapist

☐Chiropractor ☐ Acupuncture ☐Other: _____

What tests have you had for your symptoms & where were they performed?

☐ X-rays Date: _____ Where: _____

☐ MRI Date: _____ Where: _____

☐CT Scan Date: _____ Where: _____

Are you currently taking any medication? ☐ Yes ☐ No

Medications: _____

_____

Have you had any of the following? Please check yes or no:

High Blood Pressure	☐ Yes ☐No	Hernia	☐Yes ☐ No	Previous Surgery	☐ Yes ☐ No
Heart Attack	☐ Yes ☐No	Seizures	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Night Pain	☐ Yes ☐ No	Nervous Disorders	☐Yes ☐ No
Pacemaker	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Headaches	☐ Yes ☐No	Arthritis	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No

Please give a brief explanation and dates for any marked "Yes" above:

_____

Do you have any medical conditions that are not listed above? ☐ Yes ☐ No

If yes, please list: _____

Indicate if you or any of your immediate family member have/ had any of the following conditions:

☐ Arthritis ☐ Blood Disorders ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Epilepsy

☐Other_____

Informed Consent For Chiropractic Treatment and Care

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures by the doctor or intern affiliated with Empower Health & Performance

I understand that, as in the practice of medicine, in the practice of chiropractic care, 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. I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below, I consent I have read or have had read to me the above consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient or Guardian's Signature Date

Financial Office Policies

1. I understand I am financially responsible for all treatment I receive at Empower Health & Performance. If I have insurance, it will be verified promptly and will be reviewed with me. Cash, credit card (Mastercard, Visa, American Express), or checks are acceptable forms of payment for these services.
2. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services at the time of visit
3. The office will submit an insurance claim for you. We will not enter any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered. If they deny any part of a submitted claim I understand and agree to pay the remaining balance on my account after the claim has been processed.
4. I authorize the release of any medical information necessary to process any claims from this office.
5. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any needs to be taken or is the check on assignment to this office.
6. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
7. I understand there will be a $25.00 fee for all returned checks.

I have read and fully understand the financial office policies and agree to abide by these terms.

_____ _____

Patient or Guardian's Signature Date

Assignment & Instruction: For Direct Payment to Doctor

I hereby instruct the above name Insurance Company to pay by check made out to and mailed directly to. If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

Schuelke and Wilson Chiropractic Corporation
DBA Empower Health & Performance
5836 Corporate Ave Suite 120
Cypress, CA 90630

This is a direct assignment of my rights and benefits.

_____ _____

Patient or Guardian's Signature Date

Cancellation / No Show Policy

To respect the schedule of the providers, and patients on the waiting list we require a **24 hour** advanced notice for cancellation of appointments. Empower Health and Performance reserves the right to charge a fee of **$30.00** fee for all appointments that are not canceled 24 hours in advance or for appointments patients do not show up without warning.

"No Show/ Cancellation" fees will be billed to the patient and are not covered by insurance. This fee must be paid prior to your next appointment. Multiple "no shows/cancellations" may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Patient or Guardian's Signature Date

Consent for Text Message Reminders

Patients in our practice can be contacted via text messaging to remind you of an appointment.

[ ] I consent to receiving appointment reminders by text message
[ ] I do not consent to receiving appointment reminders by text message

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

_____ _____

Patient or Guardian's Signature Date

Card on File Consent

I authorize Empower Health and Performance to process the credit/debit/HSA or FSA card "saved on file" for charges associated with the office visit or cancellation/ no show fees after or during each appointment. When I come in for an appointment, my card will be scanned via the card reader, which will then be saved in ChiroTouch's secured, HIPPA-compliant server for future transactions. When the card is saved, only the last four digits of the card will be visible by office staff. I understand this authorization will remain in effect until the expiration of the credit card account. If the credit card expires, I will promptly provide the office with a new form of payment. I may also revoke this consent by notifying the practice via written request.

_____ _____

Patient or Guardian's Signature Date