SALT VALLEY CHIROPRACTIC
872 W Heritage Park Blvd, Ste 130
LAYTON, UT 84041
(801) 784-7104

PATIENT INFORMATION

PATIENT NAME

Last Name _____ First Name _____ Middle _____

Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer Name _____ Phone _____

Employer Address _____

City _____ State _____ Zip _____

SPOUSE OR GUARDIAN

Last Name _____ First Name _____ Middle _____

Employer Name _____ Phone _____

Date of Birth ____ / ____ / ____ SS# _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last Name _____ First Name _____ Middle _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relation to Patient _____

PAYMENT METHOD For all services that are not paid by a third party.

☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ _____

Signature of patient or person acting on patient's behalf Date

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MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____

Signature of patient or person acting on patient's behalf Date

MEDICAL AND HEALTH HISTORY

Date _____ Patient Name _____ Date of Birth _____

Main Problem

What pain causes you to come to the office?_____

What caused this pain? _____

When did this pain start? _____ How long does this pain last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Carmping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,

Lighteninglike, Throbbing, Nagging, Burning Deep, Stinging, Pressurelike

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other Problem

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____ How long does this pain last?_____

How bad is this pain? (Circle one - 1= mild pain - 10= intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain:

Carmping, Aching, Dull, Sharp, Shooting, Bright, Diffuse,

Lighteninglike, Throbbing, Nagging, Burning Deep, Stinging, Pressurelike

How often does the pain occur? (Circle one) Occasional, Frequent, Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse? _____

What else have you done to treat this pain? _____

Other History

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Do you drink? ☐ Yes ☐ No If yes, how much?_____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? _____

Are you pregnant? ☐ Yes ☐ No Date of last physical exam _____

Are you employed ? ☐ Yes ☐ No Where _____

How is your overall health? _____

List past illnesses_____

_____

Surgeries / Hospitalizations / Injuries	Medications	Purpose

(Use other side if necessary)

History Questionnaire

Name: _____ Occupation: _____

Date: _____ Age: _____

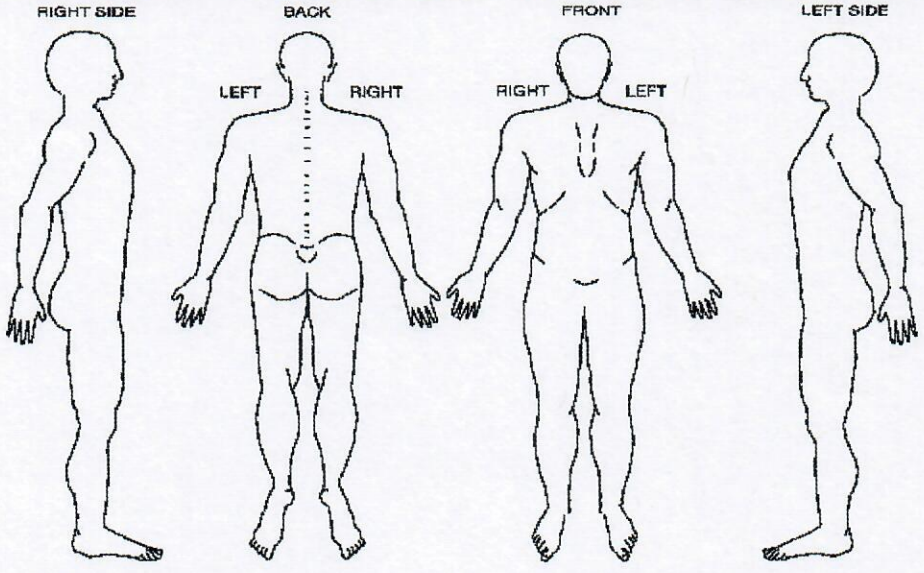
TO THE BEST OF YOUR KNOWLEDGE, DO YOU HAVE OR HAVE YOU HAD:

1.	High Blood Pressure	☐No ☐ Yes ☐ Fam.
2.	Heart Disease/Heart Attack	☐No ☐ Yes ☐ Fam.
3.	Chest Pains/ Angina	☐No ☐ Yes ☐ Fam.
4.	High Cholesterol	☐No ☐ Yes ☐ Fam.
5.	Pacemaker	☐No ☐ Yes ☐ Fam.
6.	Shortness of Breath	☐No ☐ Yes ☐ Fam.
7.	Asthma	☐No ☐ Yes ☐ Fam.
8.	Allergies	☐No ☐ Yes ☐ Fam.
9.	Chronic Bronchitis	☐No ☐ Yes ☐ Fam.
10.	Blood Disorder	☐No ☐ Yes ☐ Fam.
11.	Emphysema	☐No ☐ Yes ☐ Fam.
12.	Bleeding/Bruising	☐No ☐ Yes ☐ Fam.
13.	Anemia	☐No ☐ Yes ☐ Fam.
14.	Diabetes	☐No ☐ Yes ☐ Fam.
15.	Hypoglycemia	☐No ☐ Yes ☐ Fam.
16.	Lightheadedness	☐No ☐ Yes ☐ Fam.
17.	Dizziness	☐No ☐ Yes ☐ Fam.
18.	Concussion	☐No ☐ Yes ☐ Fam.
19.	Fainting Disorders	☐No ☐ Yes ☐ Fam.
20.	Anxiety/ Panic Attack	☐No ☐ Yes ☐ Fam.
21.	Arthritis/ Joint Pain	☐No ☐ Yes ☐ Fam.
22.	Artificial Joints	☐No ☐ Yes ☐ Fam.
23.	Kidney Disease/ Stones	☐No ☐ Yes ☐ Fam.
24.	Hepatitis	☐No ☐ Yes ☐ Fam.
25.	Spinal Cord Injury	☐No ☐ Yes ☐ Fam.
26.	Traumatic Brain Injury	☐No ☐ Yes ☐ Fam.
27.	Ulcer	☐No ☐ Yes ☐ Fam.
28.	Stroke	☐No ☐ Yes ☐ Fam.
29.	Blood in Stool/Ulcers	☐No ☐ Yes ☐ Fam.
30.	Abdominal Pain	☐No ☐ Yes ☐ Fam.
31.	Thyroid Problems	☐No ☐ Yes ☐ Fam.
32.	Polio/ Muscle Disease	☐No ☐ Yes ☐ Fam.
33.	Migraine/ Cluster Headache	☐No ☐ Yes ☐ Fam.
34.	TMJ Disorder	☐No ☐ Yes ☐ Fam.
35.	Chills/Fever/Sweats	☐No ☐ Yes ☐ Fam.
36.	Chronic Headache	☐No ☐ Yes ☐ Fam.
37.	Swelling of Extremities,	☐No ☐ Yes ☐ Fam.
38.	Sleep Disorders	☐No ☐ Yes ☐ Fam.
39.	Depression	☐No ☐ Yes ☐ Fam.
40.	Fibromyalgia	☐No ☐ Yes ☐ Fam.
41.	Chronic Fatigue Syndrome	☐No ☐ Yes ☐ Fam.
42.	Lyme Disease	☐No ☐ Yes ☐ Fam.
43.	Chronic Pain	☐No ☐ Yes ☐ Fam.
44.	Night Pain	☐No ☐ Yes ☐ Fam.
45.	Unexplained Pain	☐No ☐ Yes ☐ Fam.
46.	Unexplained Weight Loss	☐No ☐ Yes ☐ Fam.
47.	Cancer/Tumor/Growths	☐No ☐ Yes ☐ Fam.
48.	History of Smoking	☐No ☐ Yes ☐ Fam.
49.	Are you pregnant?	☐No ☐ Yes ☐ Fam.
50.	Gynecological Disorder	☐No ☐ Yes ☐ Fam.
51.	Bladder Incontinence	☐No ☐ Yes ☐ Fam.
52.	Bowel Incontinence	☐No ☐ Yes ☐ Fam.
53.	Fractures	☐No ☐ Yes ☐ Fam.

Date: _____Area: _____

Any other complaint? ☐No ☐ Yes Please Explain: _____

MARK THE ARES ON YOUR BODY WHERE YOU FEEL ANY PAIN OR DISCOMFORT.



Patient Signature_____ **Staff Signature**_____

Salt Valley Chiropractic & Nutrition Clinic
872 Heritage Park Blvd Ste #130
Layton, UT 84041

INSURANCE INFORMATION

Date _____ Patient Name _____ Date of Birth _____

INSURANCE TYPE Check all those that apply

SELF INSURANCE (CONSUMER DIRECTED)	EMPLOYER SPONSORED (PRIVATE SECTORS)	GOVERNMENTS (PUBLIC SECTORS)	OTHER TYPES
☐ Personal Health Insurance (not sponsored by employer)	☐ Group Health Insurance	☐ Medicare Part B	☐ Personal Injury (Auto, etc.)
☐ Health Savings Account (HSA)	☐ Self-Funded Benefit Plan	☐ Medicare Part C	☐ Workers' Compensation
☐ Medicare Savings Account (MSA)	☐ Private Schools	☐ Medicaid	☐ Church
☐ Other _____	☐ Health Reimbursement Arrangement (HRA)	☐ Municipal (city, state, etc.)	☐ Other _____
		☐ Other _____	

INSURANCE We need a copy of your card(s) for our records.

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

Insurance Company _____ Phone # ( ) _____
Insured's Name _____ ID/Policy # _____

RESPONSIBLE PARTY Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____
Relationship to Patient _____ SS# _____
Home Address _____ Apt# _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____
Employer Name _____ Phone _____

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____
Signature of patient or person acting on patient's behalf Date

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____ _____
Signature of patient or person acting on patient's behalf Date

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Salt Valley Chiropractic & Nutrition Clinic:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

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PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

Patients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Patients with a deductible have two options:

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.
2. You can pay our Time of Service fees, which are significantly less than our regular fees. However YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 30 days old is considered delinquent. A re-billing fee of 1.5%, (based on the outstanding balance, per month) will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be referred to a collection agency of our choice for collection which may include possible blemishes on your credit record. If this happens, an administrative collection fee of $100 (minimum) may be added to your account to cover our costs and you specifically authorize us to run your credit report.

If your insurance denies payment for any reason, we will offer you our time of service discount (our lowest fee schedule) for any outstanding charges that are paid in full within 15 days of notice.

I authorize payment of insurance benefits directly to Salt Valley Chiropractic & Nutrition Clinic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Parent of Legal Guardian) Date