



ALLSTAR CHIROPRACTIC

Personal Information

Patient Name: _____
(First) (Middle Int.) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

Birth date: ____/____/____ Age: ____ Social Security # ____-____-____

Sex: ____ M ____ F

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

Work Phone: () _____ E-mail: _____

Employer: _____ Job description: _____

Referred to this office by:

****Please present your insurance card to the receptionist to be photocopied****

Please read the following carefully:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic 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 or professional services rendered to me will be immediately due and payable and I will be responsible for any necessary collection costs.

Signature of Patient: _____ Date: _____

(Guardian if patient is under 18 years of age)

Office use only: _____



Financial Policy

Thank you for choosing All Star Chiropractic & Wellness as your health care provider. We are committed to the success of your care. Please understand that payment is considered part of your care. The following is a statement of our **Financial Policy**, which we require you to read and sign prior to any care. Dr. James R. DuPuy, D.C., is in-network with **most** insurance plans. We will discuss and advise, **but ultimately it is your responsibility to understand what services are covered under your insurance policy.** We will check your insurance policy to determine your coverage. To prevent any misunderstandings about your insurance coverage and our billing / collections procedure, we would like to inform our patients that we cannot render services under the ASSUMPTION that we will be reimbursed by your insurance company. Please understand that you will be fully responsible for all professional services that your insurance company does not pay.

It is our policy to:

1. Collect all co-pays at the time services are rendered.
2. Collect full payment for cash patients the day services are rendered. If payment is not collected on the day of service, the time of service discount will no longer apply and you will be billed the full standard fee.
3. Charge a \$35 late fee on all returned checks.
4. Massage therapy is a non-reimbursable service and therefore will not be billed to any insurance provider. Massage therapy is considered a cash service. Payment is expected at the time of service.

Usual and Customary Rates

All Star Chiropractic & Wellness is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Assignment of Insurance Proceeds

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, diagnostic testing, or any other reimbursable treatment or evaluations you receive to our clinic directly. In exchange for services and supplies rendered, I do assign to All Star Chiropractic & Wellness, any insurance proceeds, including accident and health insurance benefits and bodily injury claim awards up to the amount of any unpaid balance with interest as allowed by law.

Signature _____ Date _____

Missed Massage/Chiropractic Appointment Policy

Appointments that are **not** cancelled within 24-hours are subject to a cancellation fee of:
\$30.00 for Massage Therapists * \$25.00 for Chiropractic Care

Cancellation fees must be paid prior to rescheduling

Signature _____ Date _____

Office use only: _____



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic, medical doctors and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
- b) There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
- c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature (Legal Guardian)

Witness of Signature

Name: _____
(please print)

Name: _____
(please print)

Office use only: _____



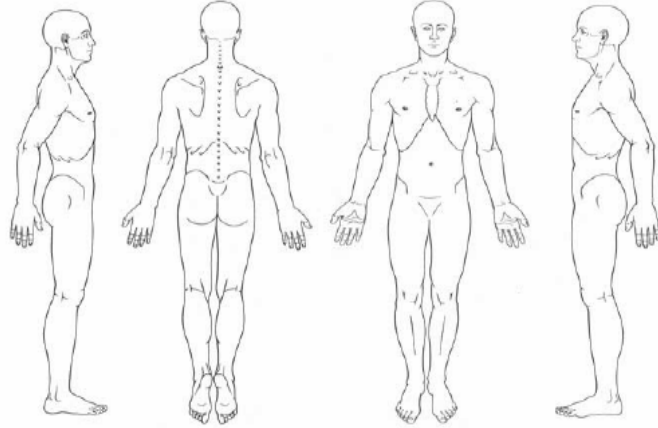
ALLSTAR CHIROPRACTIC

Patient Name _____ Date _____

1. When did your symptoms start: _____ Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ Severe, no activity possible

7. What activities make your symptoms worse:

8. What activities make your symptoms better:

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature _____ Date _____

Office use only: _____



ALLSTAR CHIROPRACTIC

Patient Name _____ Date _____

What type of regular exercise do you perform?

① None ② Light ③ Moderate ④ Strenuous

What is your height and weight?

Height
Feet Inches

Weight lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Use Tobacco Products
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Cancer			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			

Females Only

Birth Control Pills

Hormonal Replacement

Pregnancy

Other Health Problems/Issues

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____

Office use only: _____



ALLSTAR CHIROPRACTIC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at All Star Chiropractic & Wellness we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or other professional agency.

Any use or disclosure of your protected health information, other as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at another address other than your home or if you would like this information in a different form, please advise us in writing as to your preferences.

Office use only: _____



ALLSTAR

CHIROPRACTIC

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. James R. DuPuy, D.C.

If you would like further information about our privacy policies and practices please contact our privacy officer Dr. James R. DuPuy, D.C. at (614) 891-1800.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature Date

If you are a minor, or if you are being represented by another party:

Personal Representative Printed

Personal Representative Signature Date

Relationship to Patient

Office use only: _____



ALLSTAR CHIROPRACTIC

Insurance Information

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Subscriber Name: _____

Subscriber Address: _____

Subscriber Date of Birth: _____

Office use only: _____