Dr. Kenneth Price
2723 S. 108th St.
West Allis, WI 53227
(414) 763-4673

Welcome to our office! Please fill in all information completely and sign and date where appropriate. If you have any questions, please feel free to ask a member of our office staff.

Patient's Name:_____

Sex: Male / Female **Date of birth: ____/____/_____** **Age:_____**

Address _____

City _____ **State** _____ **Zip** _____

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

E-mail _____ **Social Security #** _____

Occupation _____ **Employer** _____

Marital Status (circle one): Single / Married / Divorced / Separated / Widowed

Race/Ethnicity: Caucasian (white) / African American (black) / Hispanic / Asian / American Indian / Other_____

Spouse's Name ___ _____

Name and age of children _____

_____

How did you hear about us? _____

Primary physician:_____ **Location/Clinic Name:**_____

Phone # _____ **Date of last visit**_____ **Reason**_____

May we communicate with your PCP regarding your care? Yes / No

Is this an auto or work related injury? Yes / No

Date of accident _____ **Claim #** _____

Insurance company _____ **Policy #** _____

Insured's name _____ **Insured's birth date** _____

Patient Signature _____ **Date** _____

PRICE CHIROPRACTIC

HISTORY INTAKE FORM (page 2)

PATIENT NAME:_____

Chief complaint (be specific) _____

When did this episode start? _____ Have you had similar complaints previously? Yes / No

What do you think caused your symptoms? _____

_____

Describe your symptoms (circle all that apply): aching / burning / cramping / numbness / tingling / throbbing / sharp / shooting / spasms / headache / migraine

Is your pain: mild / moderate / severe **How often is the pain?** constant / comes & goes / occasional

With 10 being the most severe, please rate your symptoms:

Currently	1 2 3 4 5 6 7 8 9 10
Worst	1 2 3 4 5 6 7 8 9 10
Best	1 2 3 4 5 6 7 8 9 10

When is your pain the worst? a.m. / noon / evening / night / all day / random

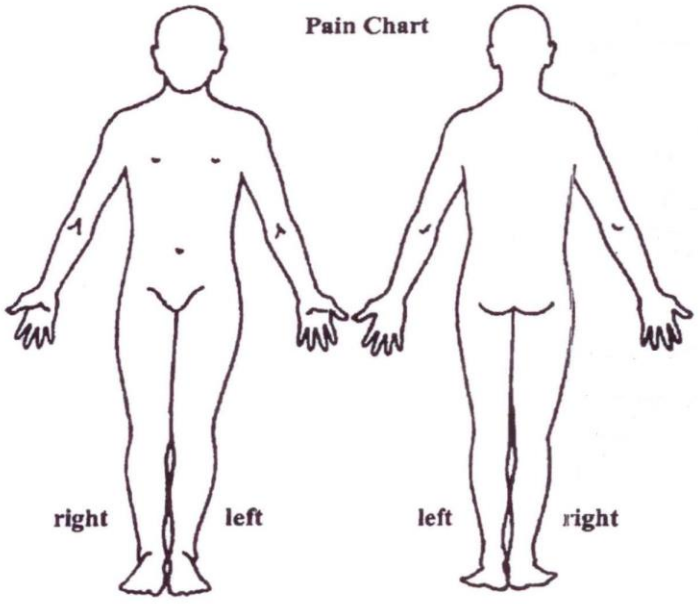
What aggravates your symptoms? standing / sitting / driving / bending / lying / sleeping / walking / other_____

What relieves your symptoms? standing / sitting / driving / bending / lying / sleeping / walking / other_____

What other treatment have you tried? ice / heat / massage / stretching / medications / injections / electric stim / chiropractic / physical therapy / other _____

Mark your symptoms on the pain chart with the appropriate symbols:

Aching	**X X X X**
Sharp	**/ / / / / /**
Numbness	**O O O O**
Tingling	**. . . . . .**
Other	*** * * * ***



Patient Signature _____ Date _____

PRICE CHIROPRACTIC

HISTORY INTAKE FORM (page 3)

PATIENT NAME:_____

Social History: **Do you smoke?** Yes / No **If yes, how much?**_____

Do you drink any alcohol? Yes / No **If yes, how much?**_____

Do use recreational drugs? Yes / No **If yes, which ones?**_____

How do you sleep? back / side / stomach **How old is your mattress?_____ How many pillows?___**

List all medications you currently take including vitamins and supplements (include dose):

_____

_____

List all allergies that you have: _____

_____

Past trauma/accidents_____

_____

Past surgeries (list procedure, date, and surgeon's name)_____

_____

_____

Health problems_____

_____

Immediate family health problems _____

_____

Have you had any tests performed regarding this complaint? X-rays / MRI / CT scan / blood tests / EMG / NCV / other _____

If so, when and what were the results? _____

Height _____ Weight _____

List any other complaints that you would like to be looked at _____

_____

What would you prefer to have treated/adjusted? Entire body / Only complaint region

Patient Signature _____ Date _____

Price Chiropractic HIPAA/Privacy Policy

Consent for Purposes of Treatment, Payment & Healthcare Operations (03/2012)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Price Chiropractic Services,LLC.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 2723 S. 108th St, West Allis,WI 53227. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient

_____

Date of Signing

Consent For Medical Treatment And Release Of Information

In this document "I" refers to the patient

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Price Chiropractic.
2. **Authorization for Release of Information:** Price Chiropractic may release information from my medical records to any health care provider involved in my care and treatment. Price Chiropractic may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Price Chiropractic is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Price Chiropractic which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Price Chiropractic, I understand that a delinquent charge of $5 per month may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Price Chiropractic. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.

   _____I want my insurance to be billed and I understand what my benefits are.

   _____I want to pay the time-of-service rate and understand that my insurance won't be billed.

4. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Price Chiropractic charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Price Chiropractic.
6. **Charge for No Show:** I understand that notice is required for canceling an appointment *before my scheduled appointment time.* If I do not call before the scheduled appointment time, it will be considered a no show appointment. I understand I will not be charged for my first no show appointment, but that I will be charged a $25.00 fee for any further missed appointments without required notification. I also understand that *I will be responsible for this charge* and that my insurance company will not be billed for that day.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Price Chiropractic HIPAA Policy.**

_____ _____

Signature of Patient or Legally Responsible Person Name (Please print)

_____ _____

Relationship/Reason Why Patient Is Unable to Sign Date