

**PANCHESIN CHIROPRACTIC CENTER**  
**5311 SOUTH 12<sup>TH</sup> AVENUE**  
**TUCSON, AZ 85706**  
**(520) 294-0400**

**(PLEASE PRINT)**

**DATE** \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Age** \_\_\_\_\_  Male  Female  
**# of Children** \_\_\_\_\_  Married  Single  Divorced  Widowed **Spouse's name** \_\_\_\_\_  
(or parent)

**Occupation** \_\_\_\_\_ **Employed by** \_\_\_\_\_ **Work Phone #** \_\_\_\_\_  
**Work Address** \_\_\_\_\_ **City, State, Zip** \_\_\_\_\_

**How were you referred to our office? Friend's name** \_\_\_\_\_ **Other** \_\_\_\_\_

**Have you ever had chiropractic care before?** \_\_\_\_\_ **If yes, when?** \_\_\_\_\_

List your chief complaints in order of severity:

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

List other Doctors consulted for this condition:

1. \_\_\_\_\_ Address \_\_\_\_\_
2. \_\_\_\_\_ Address \_\_\_\_\_

**Is this injury or illness work related?** \_\_\_\_\_ **Have you reported it to your employer?** \_\_\_\_\_

**Is this injury or illness related to an automobile accident?** \_\_\_\_\_ (If yes, name of **YOUR:**)

**Auto Insurance Co.** \_\_\_\_\_ **Policy#** \_\_\_\_\_ **Claim #** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Agents Name** \_\_\_\_\_

**Do you have any type of Health Insurance?** \_\_\_\_\_ **Company?** \_\_\_\_\_

**Address** \_\_\_\_\_ **Policy #** \_\_\_\_\_

**Are you covered under any other group or individual health policy through yourself or spouse?** \_\_\_\_\_

**If yes, Company's Name** \_\_\_\_\_ **Address** \_\_\_\_\_

**Spouse's Social Security #** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Address** \_\_\_\_\_ **City, State, Zip** \_\_\_\_\_

**Method of payment you plan to use for today's charges:**  Check  Cash  MasterCard  Visa

**NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:**

1. **ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED.**
2. **THE FEE PAID FOR TREATMENT OF X-RAYS IS FOR ANALYSIS ONLY. THE FILM ITSELF IS THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES THEY CANNOT BE RELEASED.**

**Patient's Signature** \_\_\_\_\_

**Emergency Contact Name and Phone Number** \_\_\_\_\_

**Primary Physician Name and Phone Number** \_\_\_\_\_

**Email Address** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**PANCHESIN CHIROPRACTIC CENTER**  
**5311 SOUTH 12<sup>TH</sup> AVENUE**  
**TUCSON, AZ 85706**  
**(520) 294-0400**

**HEALTH QUESTIONNAIRE:**

Please indicate for each of the questions below your experience by use of the following codes:  
 1-never had, 2- previously had, 3- presently have.

**MUSCULO-SKELETAL SYSTEM**

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problem
- Leg problem
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?  
 yes  no

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

**CARDIO-VASCULAR-RESPIRATORY SYSTEM**

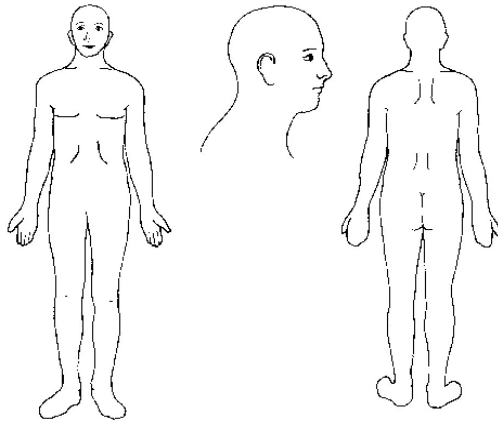
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure
- Heart problems
- Lung problems
- Varicose veins

**EYE, EAR, NOSE, & THROAT**

- Eye stain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

**NERVOUS SYSTEM**

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



\_\_\_\_\_  
 Patient's Signature

-----DO NOT WRITE BELOW THIS LINE-----

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient accepted?  Yes  No      Doctor's Signature \_\_\_\_\_

**PANCHESIN CHIROPRACTIC CENTER  
5311 SOUTH 12<sup>TH</sup> AVENUE  
TUCSON, ARIZONA 85706  
(520) 294-0400**

**HEALTH HISTORY QUESTIONNAIRE**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Patient # \_\_\_\_\_

1) Please list all past injured joints in your body giving the approximate month and year, and all significant injuries:

\_\_\_\_\_  
\_\_\_\_\_

2) Please list all past treatment for your current condition:

\_\_\_\_\_  
\_\_\_\_\_

3) Please list all past surgeries and give approximate date:

\_\_\_\_\_  
\_\_\_\_\_

4) Please describe any home care or treatment you have done for your current condition:

\_\_\_\_\_  
\_\_\_\_\_

5) Please list all current medications you are taking, their purpose, dose, times per day, and length of time:

\_\_\_\_\_  
\_\_\_\_\_

6) Please briefly describe your family health history of your mother and father:

\_\_\_\_\_  
\_\_\_\_\_

7) Please describe your current work activities:

\_\_\_\_\_  
\_\_\_\_\_

8) Please list any allergies you may have and treatment you received for them:

\_\_\_\_\_  
\_\_\_\_\_

Do not write below this line:

.....

Review of Systems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PANCHESIN CHIROPRACTIC CENTER**

5311 South 12<sup>th</sup> Avenue  
Tucson, Arizona 85706  
(520) 294-0400

**FINANCIAL ARRANGEMENTS – HEALTH INSURANCE**

To assist our patients in determining if they has a third party responsible for their health expenses or to aid in determining if they will be reimbursed by an insurance company, we have prepared the following checklist and policy statement. Please check the applicable area.

All of the following are generally subject to a deductible to be paid by the patient and then pay a percentage of the expenses.

- 1. **GROUP HEALTH AND ACCIDENT** - My insurance company is

\_\_\_\_\_

- 2. **INDIVIDUAL HEALTH AND ACCIDENT** – My insurance company is

\_\_\_\_\_

I understand that I may be able to collect benefits from #2 in addition to #1 above.

I understand that my insurance may pay only a portion of the health costs; therefore I will pay \$\_\_\_\_\_toward my share (each week/every other week) on \_\_\_\_\_. As soon as my insurance company pays its share of my bill, the office will inform me of any balance due and I will pay the balance at that time. Any credit balance will be refunded directly to me or may be used or further care at my election.

**ASSIGNMENT AUTHORIZATION, POWER OF ATTORNEY & AGREEMENT**

**In that the office is waiting for the payment of some or all of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and,**

- 1. **I hereby assign to this office my rights to receive payments from negligent parties or form insurance companies, Payments should be payable to and mailed to:**

Name Thomas Panchesin, D.C., Panchesin Chiropractic Center  
Address 5311 S. 12<sup>th</sup> Ave., Tucson, AZ., Zip 85706  
Phone (520) 294-0400

- If my policy prohibits assignments, then check should be payable to me and sent to the above address.**
- 2. **I understand that if this office receives more than their fees, the office will pay any credit balances to me, the PATIENT.**
- 3. **I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim.**
- 4. **I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Counsel, insurance companies and negligent parties be advised that, no settlement can be effectuated without the agreement of this office or the office’s release of this specific provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to “represent” me in any way, this appointment is strictly to prevent negligent parties, attorneys or insurance companies from setting any financial relations with me without fulfilling my financial responsibilities to this office first.**
- 5. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
- 6. **A photocopy of this form shall be as valid as the original.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Information taken by

\_\_\_\_\_  
Responsible party

**Panchesin Chiropractic Center  
Dr Thomas Panchesin, 5311 S 12<sup>th</sup> Ave.,  
Tucson, Az., 85706, (520)-294-0400**

**TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature) (Date)

**Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
(Signature) (Date)

**PANCHESIN CHIROPRACTIC CENTER**  
**5311 SOUTH 12<sup>TH</sup> AVENUE**  
**TUCSON, ARIZONA 85706**  
**(520) 294-0400**

**PROFESSIONAL FEE SCHEDULE**

Initial Consultation . . . . .	No Charge
Chiropractic Examinations . . . . .	\$55-\$100
Chiropractic Office Visits (average) . . . . .	\$55-\$101
Chiropractic X-ray Studies (average) . . . . .	\$72-\$189
Doctor/Patient Conference . . . . .	\$75
Thermoscribe . . . . .	\$39

(All fees are standard and primarily based on our professional association's guidelines and on the fee schedule set by the Industrial Commission of Arizona).

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office, and you may choose the plan which best fits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please consult with the Doctor. Our main concern is your health and well-being, and we will to our best to help you.

**PLAN #1 – INSURANCE** – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us an insurance claim form, on or before your second visit, with your portion completed. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. Most patients with “deductible plus 80% pay” insurances donate a nominal fee, periodically, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Reminder, insurance companies balk at “maintenance” and long term rehabilitation. Usually you will not get much help after your initial corrective care. Most ordinary “health” policies are designed and intended to only take care of acute problems so you should plan to “get off” insurance and be on your own when you get down to once a week or less (except, possible, some accident injuries). At this point refer to Health and Life Extension Plan (ask Doctor for details).

**PLAN #2 – CASH** – Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

**PLAN #3 – WEEKLY/MONTHLY CASH AGREEMENT** – For those non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except Work Injury or Auto injury claim.

**PLAN #4 – CASH PREPAY** – Ask Doctor for details.

**PLAN #5 – INDUSTRIAL** – You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

**PLAN #6 – AUTO INJURY** – You need to supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN # \_\_\_\_\_ REQUIREMENTS

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PANCHESIN CHIROPRACTIC CENTER**  
**5311 SOUTH 12<sup>TH</sup> AVENUE**  
**TUCSON, ARIZONA 85706**  
**(520) 294-0400**

**Informed Consent for Chiropractic Care**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

**The material risk in an adjustment:** As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

**The probability of those risks:** Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

**Other treatment options for your condition can include:** Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self dosages and surgical risks including complications from either the procedure and the anesthesia.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_

Print Name	Signature	Date
------------	-----------	------

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x- ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_

Patient Signature	Date
-------------------	------

**PANCHESIN CHIROPRACTIC CENTER  
5311 SOUTH. 12<sup>TH</sup> AVENUE  
TUCSON, ARIZONA 85706  
(520) 294-0400**

**APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION  
(HIPAA)**

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized provider representative

\_\_\_\_\_  
Personal representative Printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient



**Panchesin Chiropractic Center  
5311 South 12<sup>th</sup> Avenue  
Tucson, Az 85706  
(520) 294-0400**

**MARKETING AUTHORIZATION  
(HIPAA)**

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your chiropractors and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from \_\_\_\_\_ to you. We are specifically requesting authorization to market the following products and or services to you

\_\_\_\_\_  
\_\_\_\_\_.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. (164.524). Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of \_\_\_\_\_. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Authorized Provider  
Representative

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative  
Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient

**Panchesin Chiropractic Center**  
**5311 South 12<sup>th</sup> Avenue**  
**Tucson, Az 85706**  
**(520) 294-0400**

**To Our Patients Regarding HIPPA Privacy and Our Office**

In 1996, President Clinton enacted the Health Insurance Portability and Accountability Act. It was enacted to make selling and commercial exchange of patient's private health information illegal. In my office, we have for 20 years respected patient privacy long before a law had to be passed. Those areas that we choose to make you aware within this office are the following.

1. There are partial walls and no doors surrounding our adjusting rooms. If there is a private issue that needs to be discussed, you may request a private room, and I will come in as soon as possible to discuss any matter.
2. We place patient's names on our bulletin board when they refer a new patient into this office to say, "Thank You", for referring to our office.
3. We mail Postcards to patients whom refer others to our office to thank them for the referral.
4. We mail Postcards to our patients on their birthday.
5. We type up anonymous patient testimonials with the patient's permission only identifiable by a number, to share your success story with others, thereby enlightening them to what other ailments have been helped by chiropractic.
6. We require the signing of record release authorization forms for your insurance company or attorney to release your records in this office to them for the purpose of getting paid.
7. We occasionally take pictures of our patients to put in our scrap book in our waiting room library, or temporarily place on our walls.

This is summary of our routine practices that embody the marketing release form that is in this packet. We commit to honor your privacy as we always have in the past, and now in accord with the new laws our government has established. Should you have any questions, do not hesitate to ask.

I \_\_\_\_\_, authorize Panchesin Chiropractic Center and staff to conduct the above practices with respect to my privacy, and health care.