Application for Care - Adult

Today's Date:___________________

Name: ____ Birthdate: __________________
Address:____ SSN#: ___________________
City: _______________________________________ State: ______ Zip: ________________

Home phone: _________________________ Mobile phone: _________________________
Marital status: ________ Gender :________ Number of children: _______

Employer: ____
Work phone: ________________________Type of work: ____________________________

E-MAIL ADDRESS: ____

Providing the above contact information including your address, home phone number and email address constitutes permission for us to communicate with you via these means.

What phone number is the best number to call regarding appointments reminders/health information: _____________. Can we leave a message at that number you provided? Y N

Spouses Name: _______________________________ Birthdate:______________________
Employer: _________________________________ Work phone: _____________________
Type of work: ____

Have you been adjusted by a chiropractor before? Y N

Reason for those visits: ____

Did your Previous Chiropractor recommend a care program to help you maintain better NATURAL WELLNESS year round? Y N

Doctor's name: _____________________________ Date of last visit: _________________

Do you use tobacco?: Y N
Do you drink alcohol?: Y N
Do you drink caffeinated coffee/tea/soda?: Y N
Do you use artificial sweeteners?: Y N
Do you exercise regularly?: Y N
Do you wear: Heel lifts or Insoles?: Y N
Are they the same thickness?: Y N

Client History & Re-Evaluation

Primary complaint(s): ____
____
____
____

How long have you had them?: ____

How often do they occur?: ____

What other health problems concern you besides your primary complaint that you wish you could get rid of, even if you never considered a chiropractor could help? For example, do you have any sinus problems, hormone problems, asthma, diabetes, digestive troubles, arthritis, fatigue, mood swings, troubles with sleep, sex-related concerns or any other problems at all you wish you could help get rid of?: ____
____
____
____

Is **there anyone else** in your family who has health problems, even if they are not the same as yours?

Who	What Problem	Are they local?

Before you noticed these problems, were there any **earlier accidents, injuries or physical stress** that may have injured your spine or nervous system? Example: falls, auto injuries, work injuries traumas, repetitive motion on the job, sitting at a computer for hours, etc.:
____
____

Since the time you first had these problems, what have you tried to do to get rid of them that didn't work permanently? Example: ice, heat, Over-the-Counter medications, prescription drugs, physical therapy, surgery, etc.:____
____
____
____

Continued...

While these may have given you temporary relief, **do you see that they haven't truly fixed your problem yet?:** _____ Yes _____ No

How does it make you **feel emotionally** to **still** be trying to deal with these health problems?:

____
____
____

When these problems are at their worst, how does it **interfere with your life**? **Please describe what happens to you.** For example, do you get nauseous, irritable, restricted in motion, have to lay down, go for a walk, drink alcohol, smoke cigarettes, eat junk food, take drugs, etc.?:

____
____
____
____

How do your health problems make it harder to do **your job**?: ____________________________
____

Are you less productive on your job because of your health problems?: _____ Yes _____ No
Do you enjoy your work less because of your health problems?: _____ Yes _____ No
Do you have to take more breaks?: _____ Yes _____ No
Has your boss said anything about it yet?: _____ Yes _____ No

____
____

When your problems are at their worst how does it affect **your relationship with your spouse, significant other, family or friends?** For example: Are you less fun to be with?... Do you help less around the house?... Are there certain things you can't do (or do as well as you'd like to)?: ____
____
____

Who do you think is more disappointed, you or them?: ________________________________

What **hobbies or interest**s do you have outside of work?: ______________________________

When your problems are at their worst, do they prevent you from doing or enjoying your hobby/interest?: ____
____

Continued...

Is there anything else you would do more of or just enjoy more if it wasn't for these conditions?: ____

____

Sleep is important. Healing occurs when you are asleep, and sleep is essential to a properly functioning immune system. Do you have:

1. Trouble falling asleep **due to being uncomfortable?:** _____ Yes _____ No
2. Not enough restful sleep?: _____ Yes _____ No
3. Awakening in the middle of the night?: _____ Yes _____ No
4. If yes, what time of night: __________________
5. Waking earlier than you normally would?: _____ Yes _____ No

Think back to when you were younger. How old did you think you would be before you had problems like you have now?: _____

How **young** would you feel if you didn't have these problems?: _____

IF we were able to get your body functioning better again and you could feel younger, **how valuable** would that be to you?: ____

Your health problems have been going on for weeks, months or years. If these problems go on much longer, **how much worse** do you think you will get?: ____________________________

____

Do your think you could you develop arthritis, become bedridden, become unable to function normally, become **unable provide for yourself and your loved ones financially**, become **unable to care for yourself and your loved ones physically, mentally and emotionally**, etc.):

____

____

____

At this point, would you agree that it's time to try a **new approach** with these problems?:
___Yes ___ No

On a scale of 1 - 10, with 10 being the highest, **how much do you want to get rid of your problems** and improve your level of natural wellness?: ______

Assuming that we could help you with your health problem, is there **anything** that would prevent you from **following through with the care plan** we will be presenting?: _____ Yes
_____ No

If so, what would be your **concerns**: time, transportation, etc. Please specify:

____

____

Continued...

Is your Blood PRESSURE: Low Normal High

Is your Blood SUGAR: Low Normal High

Please list ALL nutritional supplements (vitamins, minerals, herbs, etc.) that you are currently taking:____

____

____

____

____

Circle any you are taking: Cholesterol medication Blood pressure medicine
Blood Thinners Muscle relaxers Pain Pills Tranquilizers Pain killers
(including aspirin, Tylenol, Motrin, Aleve) Insulin **Other:** ________________

Please list ALL **ALLERGIES**: ____

____

____

____

Please list ALL **SURGERIES** with dates: ____

____

____

____

For Women Only:

Are you pregnant?:	Yes No	Do you have irregular cycles?: Yes No
Are you nursing?:	Yes No	Do you have breast implants?: Yes No
Are you taking birth control?:	Yes No	
Do you experience painful periods?:	Yes No	

WHAT ARE YOUR GOALS FOR YOUR CARE?...

Are you interested in **minimum RESULTS** (**Healing Chiropractic** only) or **MAXIMUM RESULTS** (**Comprehensive Natural Wellness** - Relaxing Massage, Anti-Aging Nutrition & Skin Care and Healing Chiropractic)? Please check the type of care that **you** desire so that we may be guided by your wishes whenever possible.

_____ **Healing Chiropractic Only** _____ **Comprehensive Natural Wellness Care**

HOW DID YOU FIND OUT ABOUT OUR WELLNESS CENTER?...

Please CIRCLE ALL that apply!

People: ____
(Person's name, street & city)

Sign: on Building in Windows on Sidewalk

Print Media:

Alpena School System Calendar
Alpena School System Student Folder
Business Card
Flyer

Mail: Letter Postcard

Phone Book Ad: Yellow Book or Verizon

Radio Ad: station and time of day: ____

TV Ad: channel and time of day: ____

Newspaper:

Alpena News: Ad Business Brief
"Shoppers' Express" (Free newspaper): Ad

Internet:

Search Engine - Google, MSN, Yahoo, Bing, etc.: ____________________________

FaceBook

Client Name:______________________________ Date:______________________

TERMS OF ACCEPTANCE

Please Read AND Initial EACH Item

#1. I understand that **NONE** of the **Natural Wellness SERVICES** (Chiropractic Consultations; Chiropractic Spinal Adjustments; Nutritional Consulting, Nutritional Evaluations; Nutritional Testing; Inter-Segmental Traction (IST) tables; Dry Hydrotherapy (DHT) tables; Spa Capsule Massage or Manual Massage) that are offered at or through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. ________

#2. I understand that **NONE** of the **Natural Wellness PRODUCTS (**Whole Food Vitamins, Minerals, Herbs, Hormones, Skin Care, Body Care, etc.) that are offered through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. ________

#3. I understand that it is my choice to see any other health care professional at any time (including a different type of chiropractor) – especially **IN ADDITION TO** continuing to utilize your services and products. _______

#4. I understand that **NONE** of the doctors or therapists working here heals, nor do any of the services or products offered by them heal. The **ONLY** thing that heals is the life force that animates my body. _______

#5. I understand that Kirk C. McAnsh, D.C., P.C. dba Maximum Performance Family Wellness Center disclaims any liability for consequential, incidental and punitive damages; express and implied warranties including but not limited to merchantability and fitness for a specific purpose; and any liability whatsoever in an amount greater than the amount paid by me or my insurance company or $100, whichever is greater. _____

#6. I understand that it usually takes 5 (five) adjustments over a 2 (two) week period in order for me to notice that my potential for enjoying life more has STARTED to improve. _______

#7. I understand that it USUALLY take 12 (twelve) adjustments during my 4 (four) weeks of care in order for me to be well on my way to enjoying all areas of my life more. ________

#8. I understand that I MAY "feel" worse (temporarily) as my potential for enjoying all areas of my life more starts to improve as a result of availing myself to the services and products offered by Maximum Performance Family Wellness Center. _______

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of care, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

FINANCIAL POLICY

I understand that MPFWC rates are as follows; New Client History & Consult is $99; Spinal Adjustments - between $24 & $ 70; IST (Roller Table) session is $15 DHT (Water Massage table) session is $15 and that nutritional consulting, testing varies between $50 and $110 and Whole Food Vitamins vary between $5 & $150 each - depending on my needs. I also understand that my insurance **will NOT** pay for the DHT, nutritional services & products or skin care services and products and that if I want them that I will need to pay for those out of my own pocket.

I agree to pay in full at the time of each service unless I have insurance that will help support my care. My insurance policy may require me to pay a deductible each year and/or a co-pay for each service which I agree to pay for at the time of each service.

If I have an insurance policy that pays me directly, I agree to sign the back of each check and bring it (or mail it) to MPFWC **along with all of the paperwork that came with it**, within 7 days! Failure to do so will require me to pay for all services at the time of service from that point forward.

MPFWC does not accept payment or process claims from Auto Insurance, Personal Injury Worker's Compensation. We do not bill for these claims. I agree that the reason for my visit to this office is not a result of these type of claims.

I agree to pay MPFWC a $5.00 Re-bill fee PER MONTH as well as a Service Charge of 7.0% A.P.R. on ALL balances 60 days and longer past due.

MPFWC agrees to bill my insurance company for me AS A COURTESY. However, if my insurance company has not paid within 90 days, the total amount due will be my responsibility, regardless of when I receive my statement from MPFWC or what my insurance company initially may have told MPFWC they would cover. **I understand that MPFWC can only estimate what my insurance will cover until an Explanation of Benefits or payment is received from my insurance company.**

I authorize Kirk C. McAnsh, D.C., P.C. to release any information to any insurance company, adjustor, agent or attorney that will assist in payment of a claim.

I agree to pay MPFWC $22.50 "Return Check Fee" for any and all checks that do not clear the bank.

I have received and read a copy of the following forms.

* Terms of Acceptance
* Notice of Privacy Policy
* Financial Policy

I have received a copy of these policy's. I agree with them and will keep a copy for my records.

_________________________ ___________________

Signed Date

________________________ ____________________

Witness Date