

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____
What is your major complaint? _____

Other complaints _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Yes No Constant Comes and goes
Is this condition interfering with your: Work Sleep Daily routine Other _____
How long has it been since you really felt good? _____
List surgical operations: _____

Are you taking any medications? _____ What kind? _____
Any non-prescription drugs? _____ What kind? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
Doctor's Name _____ Diagnosis _____
X-rays _____ Urinalysis _____ Blood Tests _____ Other _____
Treatment: Medication _____ Physiotherapy _____
Results _____ Length of time under care _____
Were you off work? _____ If so, how long _____ Have you returned to your same job? _____ If not, why _____

INSURANCE INFORMATION:

Are you covered by Medicare? Yes No Medicare # _____ State Insurance Aid? Yes No
Do you have any group, union or personal health and accident insurance? Yes No
Name of Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Additional Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Is your condition due to an accident? illness Other _____

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
Date _____ Time _____ Injury reported to employer Yes No Name of Supervisor _____
Description of accident _____
Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____ Treatment _____
confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Describe _____
Do you have an attorney? Yes No Name & Address _____

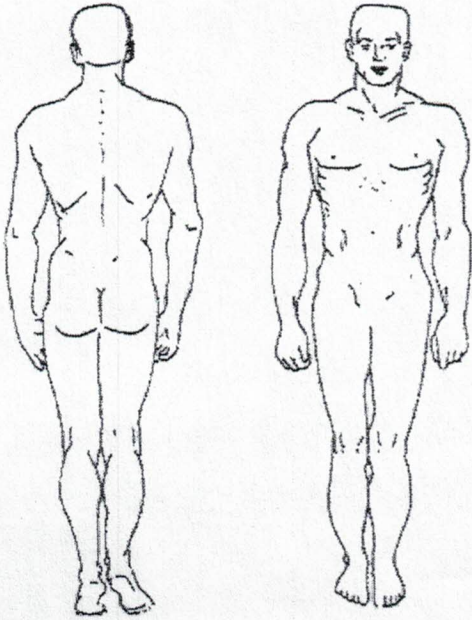
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date: _____

Name: _____

Date: _____

PLEASE MARK AN X ON THE DIAGRAM
BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you
have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the last six months:

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus Congestion / Allergies | <input type="checkbox"/> Frequent Nausea / Vomiting |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor / Excessive Appetite |
| <input type="checkbox"/> Lung Problems / Congestion | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Painful / Excessive Urination |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Discolored Urine |
| <input type="checkbox"/> Prostate / Sexual Dysfunction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual Cycle Dysfunction | <input type="checkbox"/> Cancer |

Signature _____

Date _____

**Gunderson Chiropractic
Financial Agreement**

Patient Name: _____ **Date:** _____

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

Payment Arrangements

It is our policy to maintain your account on a current basis. Charges for treatment are due at the time service is provided. If your account is NOT paid on time, it may be subject to a finance charge.

_____ Private Pay Patients: Payment is due at the time of treatment.

_____ Health Insurance Patients: Once your insurance is verified, we will go over your coverage with you. You will be responsible for any deductible, co-pay and non-covered services at the time of treatment.

Voluntary Termination of Care

If you should choose to suspend or terminate your treatment prematurely; any outstanding fees for treatment rendered to you will be immediately due and payable.

I have read and agree to the above statements:

Patient's Signature: _____

**Your questions are important to us, PLEASE ask them.
Once again, we would like to welcome you to our office. We look forward to helping you reach
your health goals.**

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient of Representative

Date

Printed Name