COUSINEAU CHIROPRACTIC CENTER, PLLC
PATIENT INTRODUCTION

Date: _____ Name: _____ Age: _____ Sex: M F

Height: _____ Weight: _____ Date of Birth: _____

Briefly describe chief complaint (symptoms):

_____

How Long? _____ Is this your first episode of pain in this area? Y N

Any falls, accidents, or injuries? _____. If yes, please explain below.

_____

What have you done to treat your condition(s)? _____

_____

Who is your primary care physician? _____

Have they consulted or treated you for this condition? _____

Have you had any tests done? Y N If yes, please list: _____

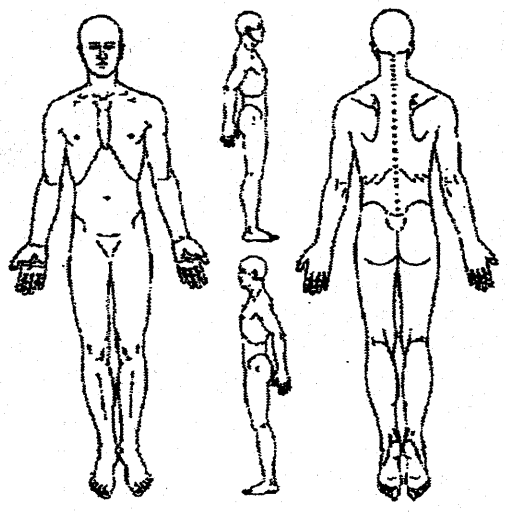
Please list any surgeries: _____

What medications are you currently taking? Please include dosages. _____

_____

Do you have any drug allergies? Y N If yes, please list: _____

Please list any illnesses: _____



Please mark the areas that need attention using the following key:

- A – Ache
- N – Numb
- P – Pins & Needles
- S – Stabbing
- O – Other

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What is your occupation? _____

Please indicate the average intensity of your symptoms 1 (Mild) to 10 (Unbearable):

_____Neck	_____Middle Back	_____Lower Back
_____Headaches	_____Arm & Hand	_____Legs & Feet
_____Shoulders	_____Ribs	_____Hip Joints

Please check any current symptoms and underline any past problems:

__Arthritis	__Loss of Memory	__Stomach Trouble
__Painful Joints	__Ringing in Ears	__Indigestion
__Swollen Joints	__Loss of Taste	__Ulcers
__Rheumatic Fever	__Sinus Trouble	__Diabetes
__Headaches	__Neck Pain	__Gall Bladder Trouble
__Shooting Head Pains	__Grating in Neck	__Mid Back Pain
__Head feels Heavy	__Tight Shoulders	__Liver Trouble
__Lights Bother Eyes	__Thyroid Trouble	__Kidney Trouble
__Wear Glasses	__Chest Pains	__Bladder Trouble
__Twitching of Face	__Heart Problems	__Constipation/Diarrhea
__Strokes	__Heart Attacks	__Pinched Nerves in Back
__Loss of Balance	__High Blood Pressure	__Disc Problems
__Dizziness	__Low Blood Pressure	__Low Back Pain
__Fainting	__Anemia	__Sexual Dysfunction
__Cold Sweats	__Shortness of Breath	__Cold Feet
__Fatigue	__Asthma	__Pains in Feet
__Stress	__Tuberculosis (TB)	__Pins & Needles in Legs
__Nerves/Nervousness	__Pins & Needles in Arms/Hands	__Allergies
__Sleeping Problems	__Cold Hands	__Cancer

What are your healthcare goals in relation to your symptoms? (Circle all that apply)

Pain/Symptom Relief	Stop the onset of Arthritis	Improved Posture
General/Overall Wellness	Improved Immune System	Increased Energy

Other: _____

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Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Sex: M F Birth Date: _____ Age: _____

Social Security Number: _____

Status: Single _____ Married _____ Divorced _____ Widow(er) _____ Separated _____

Employed _____ Retired _____ Full Time Student _____ Part Time Student _____

Patient Employer: _____ Employer Phone: _____

Have you ever served in the U.S. Military? Yes No

If yes, which branch? _____

What is your rank currently or at the end of your military service? _____

Insurance Information

Do you have a flex-spend or health savings account? Yes No

Name of Insurance: 1. _____ 2. _____

Patient Relationship to Insured: Self _____ Spouse _____ Dependent _____ Other _____

Insured's Name: _____ Employer: _____

Insured's Street Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Home Phone: _____ Insured's Business Phone: _____

Insured's Social Security Number: _____ Insured's Birth Date: _____

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Patient Name: _____ Date of Birth: _____
(Please Print)

For Pediatric Patients Only:

Mother (or Legal Designee): _____
(Please Print)

Father (or Legal Designee): _____
(Please Print)

How Our Office Should Reach You:

What number should we call?		( ) HOME CELL WORK	
Is this your primary phone number?	YES NO	May we leave a message or voice mail?	YES NO
Are there other numbers we could use?	____ NO	( ) HOME CELL WORK	
		May we leave a message or voice mail?	YES NO
		( ) HOME CELL WORK	

SHARE *Cousineau Chiropractic Center* may share any health information about me with the following family members and/or friends who are, or may be, involved in my care:

FULL NAME

Do **NOT** share my health information with the following:

FULL NAME

My signature below indicates that I have completed the above sections to the best of my ability. I understand that I may change the responses provided at any time by making a change in writing.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian

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Insurance Assigoment Program

It is our desire to assist our patients whenever possible. The following assignment program allows you, our patient, to receive the care you need without undue financial strain. Waiting for insurance payment is a courtesy provided by this clinic. This clinic does not promise that an insurance company will pay. It is your responsibility to:

1. Supply us with a copy of your most recent insurance card on the **first day** service is rendered. If multiple insurances are involved all information must be received at our clinic **within 5** days.
2. Inform our office of **any** insurance change.
3. Pay **all** deductibles and co-pays.
4. Bring the check and explanation of benefits to this office within **one week** of receipt and endorse it over to the clinic if you receive payment from your insurance carrier during the period of assignment. If the check is not received by this clinic, you will be responsible for the **full amount billed.**
5. Pay **all** of the charges and pursue reimbursement from his/her insurance company in the event that the insurance company disputes or rejects the claim.

Please be advised this is a summary of plan benefits and does not guarantee payment. Benefits are subject to all plan terms, provisions, limitations, and exclusions, including any limitations or exclusions relating to pre-existing conditions, waiting periods, and/or elimination periods. Upon receipt, claims may be subject to investigation which may affect the availability and extent of benefits available. All expenses are limited by the plans usual and customary allowance and 'medical or chiropractic' necessity guidelines. Experimental treatment is **not** covered. The eligibility provided is the most accurate data available to us from the employer, but may not reflect the changes in status known to the employee.

I, _____, understand all of the provisions above, that my insurance carrier is being billed for services at *Cousineau Chiropractic Center, PLLC*, and that I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND COPAYS THAT I MAY OWE.

Terms of Acceptance for Chiropractic Treatment

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. 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: apply specific adjustments of the spine.

Health A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation A misalignment of one or more of the 24 vertebrae 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 or condition other than chiropractic problems per State of Michigan standards. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. 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. 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: _____

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AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I hereby authorize the *Cousineau Chiropractic Center, PLLC* to disclose to my insurance company/lawyer any and all information contained in my file.

Signature: _____ Date: _____

OWNERSHIP OF X-RAYS

I understand x-rays are for radiological exam and diagnostic evaluation. The x-rays will remain the property of *Cousineau Chiropractic, PLLC.*

Signature: _____ Date: _____

*FEMALE PATIENTS ONLY

To the best of my knowledge, I am **NOT** pregnant at this time and x-rays may be taken at this clinic.

Signature: _____ Date: _____

HIPPA PRIVACY LAW SIGNATURES

This notice is effective as of _____ (Date). This notice will expire **seven** years after the date upon which this record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
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

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PATIENT INTRODUCTION

Patient Name: _____

How did you hear about Cousineau Chiropractic Center, PLLC?

___ Movie Theatre

___ Newspaper Ad

___ Phonebook Ad

___ Sportsplex

___ Facebook

___ Employer

___ Radio Ad: Eagle 101.5

___ Website

___ Friend

___ Family

___ Doctor

___ Other: _____

If you were referred by a friend, family member, or doctor, please give us their full name:

_____