PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

PATIENT NAME

_____

DATE COMPLETED

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: _____ /_____ /_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

Have you been treated for this? ❑ Yes ❑ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what? _____ How long were you treated? _____ Last treatment: _____ / _____ / _____

How did you respond? _____

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain: _____

_____

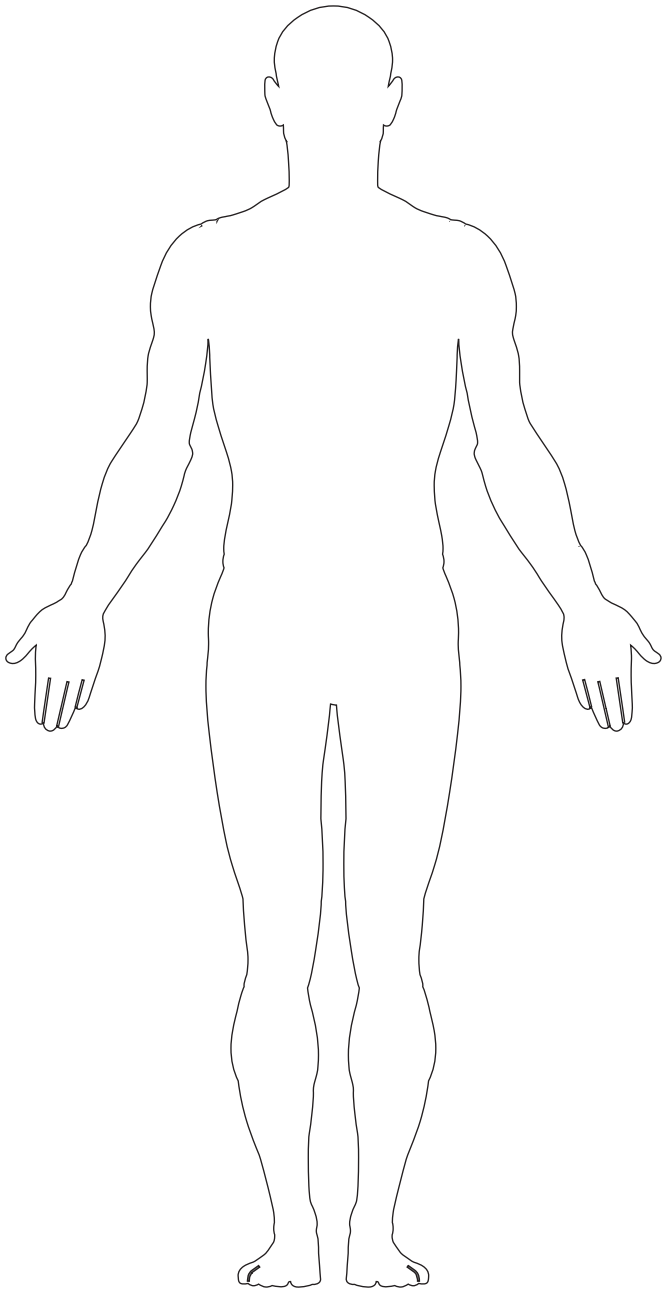
_____

_____

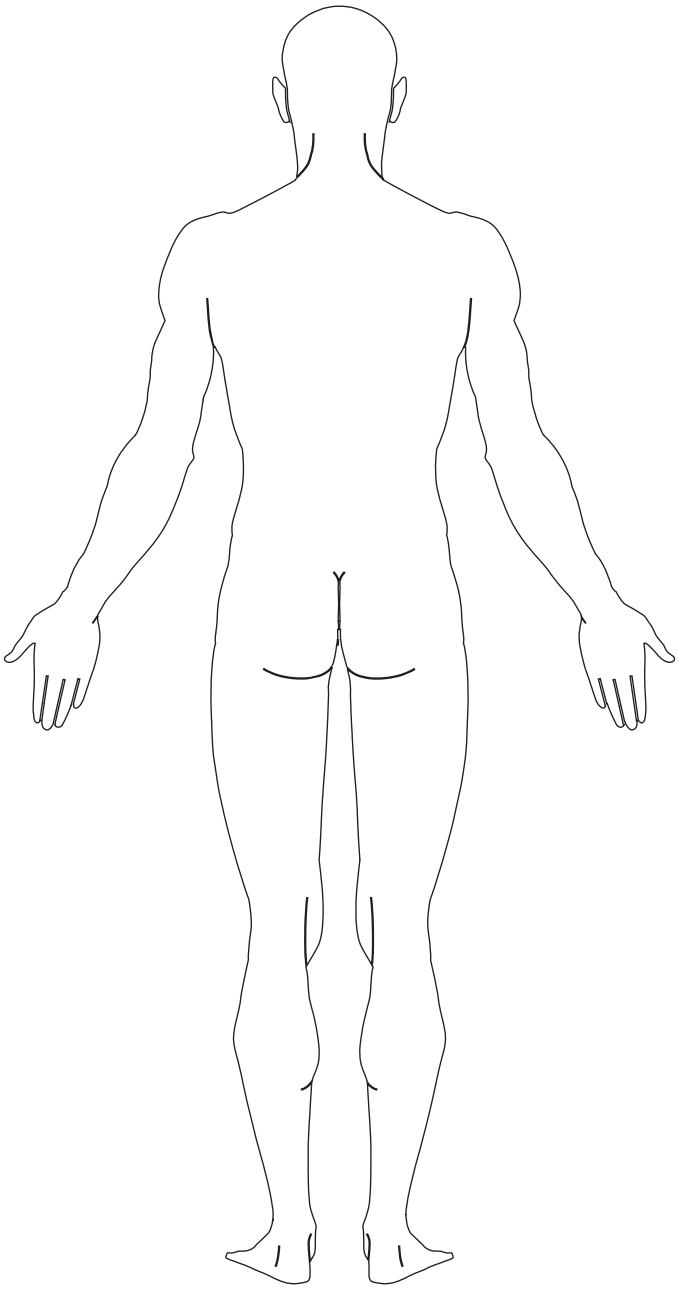
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for Other on any part, please explain below:

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often? _____ day(s) per week; Other: _____

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other: _____

Do you smoke? ❑ Yes ❑ No How much? / How often? _____

Do you drink alcohol? ❑ Yes ❑ No How much? / How often? _____

Do you drink coffee? ❑ Yes ❑ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking

Please explain: _____

_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Heart Murmurs
____ Tachycardia
____ Heart Attacks/Angina
____ Recurrent Lung Infections/Bronchitis
____ Asthma/Wheezing
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration

Please explain: _____

_____

_____

_____

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.*

Health Conditions *continued*...

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Diabetes
____ Hypoglycemia/Hyperglycemia
____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

_____

_____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Constipation/Diarrhea
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Menstrual irregularities/cramping (females)
____ Low back pain
____ Coldness in legs/feet
____ Sexual dysfunction

Please explain: _____

_____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

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's Signature _____ Date _____ /_____ /_____

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date _____ /_____ /_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____ /_____ /_____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

Patient's Signature _____ Date _____/_____/_____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____ /_____ /_____

Cancellation Policy Consent

Please help us serve you better by keeping your scheduled appointments. If you need to cancel, please let us know as soon as you are aware of your time conflict to reschedule.

It is our policy that any appointment cancelled within 24 hours whill be charged at the full rate of the appointment.

We understand that sometimes the weather may influence your ability to arrive at your appointment. We reserve the right to charge for any appointment canceled within this policy, even when inclement weather is the cause, on a case-by-case basis. Inclement weather will not immediately waive this fee.

I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for payment. I 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: _____

Signature of Person Authorizing Care (if different from patient): _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time.. This authorization will remain in effect until canceled or a new credit card authorization form has been completed and submitted to our office.

I, _____, hereby authorize Neuro Performance Integration to charge the credit car given for the amount of the agreed upon purchases of goods and/or services. I understand that my credit card will be saved on file for future transactions on my account.

Patient's Signature:_____Date: _____

Signature of Person Authorizing Care (if different from patient): _____

Consent & Release of Liability

Financial Policy: We are committed to the successful completion of your treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. Full payment is expected at the time of service. We accept cash, checks, Visa and MasterCard. We currently do not accept insurance, although we are permitted to accept HSA/FSA cards. We realize that due to the rising cost of healthcare, it makes it very difficult for the average person to receive often needed care. It is therefore our policy that no person will be turned away due to financial burdens. We have very flexible payment plans that can fit every budget.

Regarding Insurance: Our policy is to recommend what is best for each patient. What an insurance company may or may not reimburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into a dispute with an insurance company regarding reimbursement. This is the patient's responsibility. We do not know if your policy covers chiropractic care or not and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill. Insurance companies do not pay for nutritional supplementation or dietary consultations at this point, although you will be given a superbill that you can submit to your insurance company to try and seek reimbursement.

Scheduling of appointments: One of the most precious gifts is our time. To heal in a timely fashion, it is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want, and the care you need and deserve. ***Please cancel at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit.*** Please help us serve you better by keeping your scheduled appointments. Your spine can change in as little as 90 days. Therefore it is our practice that patients who haven't been treated by Dr. Shores in three (3) months or longer, must undergo a reactivation exam before resuming care.

We are here to help you and look forward to being a part of your health care team. We hope that we can find a solution to not delay treatments for financial reasons. We will do everything possible to make your care affordable so that you can follow through on your treatment schedule.

I clearly understand and agree that all services rendered to me will be 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: _____

Signature of Person Authorizing Care (if different from patient):_____

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 relates 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.

Patient's Signature:_____Date: _____

Signature of Person Authorizing Care (if different from patient):_____