# REGISTRO DE HISTORIAL QUIROPRÁCTICO

## 1 INFORMACIÓN DEL PACIENTE

Fecha _____

SS/HIC/ID Paciente _____

Nombre del Paciente _____
Apellido

_____
Primer nombre Inicial del segundo nombre

Domicilio _____

Correo electrónico _____

Ciudad _____

Estado _____ Código postal _____

Sexo ☐ M ☐ F Edad _____

Fecha de nacimiento _____

☐ Casado ☐ Viudo ☐ Soltero ☐ Menor

☐ Separado ☐ Divorciado ☐ En pareja durante _____ años

Empleador/Escuela del paciente _____

Ocupación _____

Domicilio del empleador/escuela _____

_____

Teléfono del empleador/escuela (_____) _____

Nombre del cónyuge _____

Fecha de nacimiento _____

SS# _____

Empleador del cónyuge _____

¿A quién podemos agradecer su referencia? _____

## 2 INFORMACIÓN DEL SEGURO

¿Quién es responsable de esta cuenta? _____

Relación con el paciente _____

Compañía de seguros. _____

Grupo # _____

¿El paciente está cubierto por algún seguro adicional? ☐ Sí ☐ No

Nombre del suscriptor _____

Fecha de nacimiento _____ SS# _____

Relación con el paciente _____

Compañía de seguros. _____

Grupo # _____

**CESIÓN Y DIVULGACIÓN**

Certifico que yo y/o mi(s) persona(s) a cargo contamos con cobertura de seguro de

_____ y cedemos directamente al
Nombre de la(s) Compañía(s) de Seguros

Dr. _____ todos los beneficios del seguro, si los hubiere, de otro modo pagaderos a mí por servicios prestados. Comprendo que soy responsable desde el punto de vista financiero por todos los cargos, sean o no pagados por el seguro. Autorizo el uso de mi firma en todos los documentos del seguro.

El médico arriba mencionado puede utilizar mi información sobre atención de salud y puede divulgar dicha información a la(s) Compañía(s) de Seguros arriba mencionadas y sus agentes con el fin de obtener el pago de los servicios y determinar los beneficios del seguro pagaderos por servicios relacionados. Este consentimiento terminará cuando se complete mi plan de tratamiento actual o un año después de la fecha de suscripción a continuación.

_____
Firma del paciente, padre/madre, tutor o representante personal

_____
Indicar nombre del paciente, padre/madre, tutor o representante personal

_____ _____
Fecha Relación con el paciente

## 3 NÚMEROS DE TELÉFONO

Celular (_____) _____ Teléfono del Hogar (_____) _____

Mejor momento y lugar para contactarlo _____

**EN CASO DE EMERGENCIA, COMUNICARSE CON**

Nombre _____ Relación _____

Teléfono del hogar (_____) _____ Teléfono del trabajo (_____) _____

## 4 INFORMACIÓN DEL ACCIDENTE

¿El problema de salud se debe a un accidente? ☐ Sí ☐ No Fecha _____

Tipo de accidente ☐ Auto ☐ Trabajo ☐ Hogar ☐ Otro

¿Ante quién presentó un reporte del accidente?
☐ Seguro de automóvil ☐ Empleador ☐ Compañía de seguro laboral ☐ Otro

Nombre del abogado (si corresponde) _____

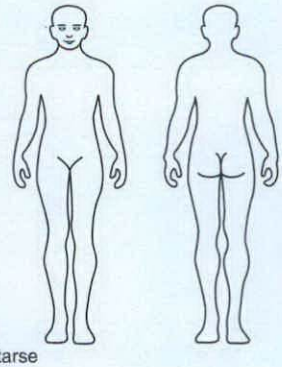
## 5 ESTADO DEL PACIENTE

Motivo de la visita _____

¿Cuándo comenzaron los síntomas? _____

¿Este problema de salud está empeorando en forma progresiva? ☐ Sí ☐ No ☐ No sabe

Marcar con una X en la figura dónde continúa sufriendo dolor, entumecimiento o cosquilleo.



Calificar la gravedad del dolor en una escala de 1 (menos dolor) a 10 (gran dolor) _____

Tipo de dolor: ☐ Agudo ☐ Leve ☐ Pulsante ☐ Entumecimiento ☐ Angustiante ☐ Punzante
☐ Ardor ☐ Comezón ☐ Calambres ☐ Rigidez ☐ Hinchazón ☐ Otro

¿Con qué frecuencia siente este dolor? _____

¿Es constante o viene y se va? _____

¿Interfiere con su ☐ trabajo ☐ sueño ☐ rutina diaria ☐ recreación

Actividades o movimientos que le resulta doloroso realizar ☐ Sentarse ☐ Pararse ☐ Caminar ☐ Inclinarse ☐ Acostarse

## 6 HISTORIAL DE S. D

¿Qué tratamiento ha recibido para este problema de salud? ☐ Medicamentos ☐ Cirugía ☐ Fisioterapia

☐ Servicios quiroprácticos ☐ Ninguno ☐ Otro _____

Nombre y dirección de otro(s) médico(s) que lo han tratado por su problema de salud _____

Fecha del último: Examen físico _____ Rayos X de columna vertebral _____ Análisis de sangre _____

Examen de columna _____ Radiografía de tórax _____ Análisis de orina _____

Radiografía odontológica _____ Resonancia magnética, tomografía computada, densitometría _____

Marcar "sí" o "no" para indicar si ha tenido:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SIDA/VIH ☐ Sí ☐ No | Enfisema ☐ Sí ☐ No | Migraña ☐ Sí ☐ No | Enfermedad de transmisión sexual ☐ Sí ☐ No |
| Alcoholismo ☐ Sí ☐ No | Epilepsia ☐ Sí ☐ No | Aborto espontáneo ☐ Sí ☐ No | Apoplejía ☐ Sí ☐ No |
| Brotes de alergia ☐ Sí ☐ No | Fracturas ☐ Sí ☐ No | Mononucleosis ☐ Sí ☐ No | Intento de suicidio ☐ Sí ☐ No |
| Anemia ☐ Sí ☐ No | Glaucoma ☐ Sí ☐ No | Esclerosis múltiple ☐ Sí ☐ No | Problemas de tiroides ☐ Sí ☐ No |
| Anorexia ☐ Sí ☐ No | Bocio ☐ Sí ☐ No | Paperas ☐ Sí ☐ No | Amigdalitis ☐ Sí ☐ No |
| Apendicitis ☐ Sí ☐ No | Gonorrea ☐ Sí ☐ No | Osteoporosis ☐ Sí ☐ No | Tuberculosis ☐ Sí ☐ No |
| Artritis ☐ Sí ☐ No | Gota ☐ Sí ☐ No | Marcapasos ☐ Sí ☐ No | Tumores, quistes ☐ Sí ☐ No |
| Asma ☐ Sí ☐ No | Enfermedad cardiaca ☐ Sí ☐ No | Enfermedad de Parkinson ☐ Sí ☐ No | Fiebre tifoidea ☐ Sí ☐ No |
| Problemas de sangrado ☐ Sí ☐ No | Hepatitis ☐ Sí ☐ No | Pinzamiento ☐ Sí ☐ No | Úlceras ☐ Sí ☐ No |
| Quiste de mama ☐ Sí ☐ No | Hernia ☐ Sí ☐ No | Neumonía ☐ Sí ☐ No | Infecciones vaginales ☐ Sí ☐ No |
| Bronquitis ☐ Sí ☐ No | Hernia de disco ☐ Sí ☐ No | Polio ☐ Sí ☐ No | Tos ferina ☐ Sí ☐ No |
| Bulimia ☐ Sí ☐ No | Herpes ☐ Sí ☐ No | Problema de próstata ☐ Sí ☐ No | Otros _____ |
| Cáncer ☐ Sí ☐ No | Alta Presión sanguínea ☐ Sí ☐ No | Prótesis ☐ Sí ☐ No | _____ |
| Cataratas ☐ Sí ☐ No | Colesterol Alto ☐ Sí ☐ No | Asistencia psiquiátrica ☐ Sí ☐ No | |
| Dependencia de fármacos ☐ Sí ☐ No | Enfermedad renal ☐ Sí ☐ No | Artritis reumatoidea ☐ Sí ☐ No | |
| Varicela ☐ Sí ☐ No | Enfermedad hepática ☐ Sí ☐ No | Fiebre reumática ☐ Sí ☐ No | |
| Diabetes ☐ Sí ☐ No | Sarampión ☐ Sí ☐ No | Fiebre escarlata ☐ Sí ☐ No | |

### EJERCICIO

☐ Ninguno
☐ Moderado
☐ Diariamente
☐ Intenso

### ACTIVIDAD LABORAL

☐ Permanecer sentado
☐ Permanecer parado
☐ Trabajo liviano
☐ Trabajo intenso

### HÁBITOS

☐ Fumar — Paquetes por día _____
☐ Alcohol — Tragos por semana _____
☐ Café/bebidas con cafeína — Tazas por día _____
☐ Alto nivel de estrés — Motivo _____

¿Está usted embarazada? ☐ Sí ☐ No Fecha de parto _____

| Lesiones/cirugías pasadas | Descripción | Fecha |
|---|---|---|
| Caídas | | |
| Lesiones en la cabeza | | |
| Huesos quebrados | | |
| Dislocamientos | | |
| Cirugías | | |

## 7

| MEDICAMENTOS | ALERGIAS | VITAMINAS/HIERBAS/MINERALES |
|---|---|---|
| | | |
| | | |
| | | |
| Nombre de la farmacia _____ | | |
| Teléfono de la farmacia (____) _____ | | |

## Akers Chiropractic Notice of Privacy Practices

Akers Chiropractic, under the HIPPA Standards for Privacy of Individually Identifiable Health Information (The Privacy Rule), modified on August 14, 2002 will:

- Collect information that is relevant and necessary to carry out our role.
- Explain at the time of the information is being collected, why it is needed, and how it will be used.
- Ensure that records are used only for the reasons given or seek the person's permission when another purpose for their use is considered necessary or desirable.
- Provide adequate safeguards to protect the records from unauthorized access and disclosure.
- Allow people to see the records kept on them and provide them with the opportunity to correct in accuracies in their records.
- Provide records to an entity, medical doctor or facility in order to coordinate your care.
- Obtain information needed to confirm your insurance benefits and obtain payment for services.
- Release information to your Insurance Plan at their request for billing or their administrative purposes.
- Release records when they are requested by you or your representative.
- Release records to certain government authorities as permitted or required by law to investigate or regulate health related issues such as child abuse, communicable diseases and prescription drugs.
- Certain lawyers and parties in a law suit if a patient's medical condition is an issue in a law suit.

Akers Chiropractic is to protect our patients privacy (Private Healthcare Information) at the same time providing them with the most efficient and effective care possible.

Authorization will be given to the person/persons written in if you should request them to have access to your Private Healthcare Information:

☐ I permit _____ to have access to my scheduling information.

☐ I permit _____ to have access to scheduling and billing information.

Please acknowledge you have read and understood the above description and understand that in order to give you the most efficient care, any and all records regarding a healthcare issue will be forwarded to the facility or physician we refer you to.

Printed Name: _____ Date: _____

Signature: _____ Witness: _____

# DR. TERRY AKERS

2931 N. Tenaya Way, Suite 106

Las Vegas, NV 89128

(702) 822-1212 FAX (702) 839-0964


## INFORMED CONSENT
## DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

**CHIROPRACTIC**

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This give the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

**ANALYSIS**

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

**DIAGNOSIS**

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialist. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedure whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialize, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

**RESULTS**

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

**TO THE PATIENT**

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

_____ _____

**SIGNATURE** **DATE**


*Dr. Terry Akers*
Chiropractic Physician

Tel (702) 822-1212
Fax (702) 839-0964
2931 N. Tenaya Way
Suite #106
Las Vegas, NV 89128

# FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have questions or concerns about our payment policies, please do not hesitate to ask our Billing Manager.

All deductibles, co-payments and applicable charges are due at the time of services- NO EXCEPTIONS. We accept cash, checks, and for your convenience, MasterCard, Visa, Discover, and American Express. If **Akers Chiropractic** is affiliated with your preferred provider (contracted insurance company), we will submit the claim to your insurance company. If your insurance coverage/company changes, it is your responsibility to notify our office immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. You are responsible for these amounts.
3. YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS! Does your insurance require a Primary Care Physician (PCP) Referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of assistance, please let us know.
4. If the insurance company does not pay in full within 30 days, we ask that you contact the insurance carrier. If your insurance does not pay in full within 45 days, we require you to pay the balance due with cash, check, or credit card.
5. It is your responsibility to provide your insurance company with any requested information in a timely manner. You will be responsible for the full balance of your account if claims are denied due to unanswered requests. We will be happy to assist you if you have any difficulty understanding their requests.
6. Returned checks for non-sufficient funds will be charged with an additional $25 fee, and checks will no longer be accepted as payment.
7. You are responsible for any collection fees, legal fees, or court costs.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____


*Dr. Terry Akers*
Chiropractic Physician

Tel (702) 822-1212
Fax (702) 839-0964
2931 N. Tenaya Way
Suite #106
Las Vegas, NV 89128

# ATTENTION PARENTS, GUARDIANS & GUESTS

To ensure the highest quality of care to all of our patients, children may not be left unattended in the hallways, bathroom, therapy area, or exam rooms.

If small children accompany you to your appointment, please provide adult supervision (other than yourself) during your appointment.

If your child is able to sit quietly on their own in the front waiting area they are welcome to watch children's programming while you receive your treatment.

Therapy is a time for our patients to relax as most of our patients are suffering from pain. In order to respect the courtesy of others, nobody other than the treating patient will be allowed in the therapy area.

Thank You

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____

Treating Doctor: DR. TERRY AKERS

**MEMBER NAME:** _____

**MEMBER SS#:** _____

**PATIENT NAME:** _____

**PATIENT DOB:** _____

Please indicate by checking yes or no if you have health benefits (insurance) available through the H.E.R.E.I.U./Culinary/ABPA Fund.

_____ YES _____ NO

The following are covered under the plan:

| | |
|---|---|
| Local 226 | Culinary |
| Local 369 | Musicians |
| Local 165 | Bartenders |
| Local 720 | Stage Hands |

**Signature:** _____ **Date:** _____

# Akers Chiropractic

Dr. Terry Akers
CHIROPRACTIC PHYSICIAN

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This is to authorize that medical information regarding: _____
Patient Name

_____ _____
Social Security # Date of Birth

Be forwarded from: _____
Physician or Facility Name Phone/Fax

_____
Street Address City State Zip

**To: Akers Chiropractic**
**2931 N. Tenaya Way, Ste. #106**
**Las Vegas, NV 89128**
**Phone: (702) 822-1212**
**Fax (702) 839-0964**

Information Requested:

☐ X-Rays (type) _____ (date taken) _____

☐ X-Ray/ MRI Reports _____

☐ Copies of chart notes _____

☐ Laboratory/Pathology reports _____

☐ EMG or other special reports _____

☐ Billing & Full Records _____

☐ All Available/ other _____

_____ _____ _____
Date Authorizing signature Relationship to patient