WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

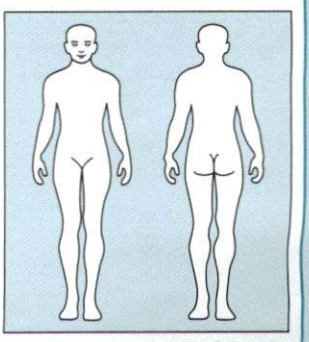
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (_____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS

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: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

As a patient in our office, you have the right to know about the type of treatment we will use, and complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these prior to treatment and receive your written consent for you or your minor child.

The primary treatment used by Chiropractic Physicians is the adjustment or manipulation of the joints of the body to include motion. The doctor will use the procedure most appropriate to treat your condition as well as ancillary treatments such as prescribing exercises, and using therapeutic modalities.

The nature of the Chiropractic Adjustment: I will use my hands and/or mechanical device upon your body in such a way as to move the joints to restore normal function. This procedure may cause an audible "click" or "pop" sound similar to what you feel when you pop your knuckles. You may feel or sense movement of this joint, which usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there is other less forceful and gentler type of adjustments that may be used.

The possible risk involved in the Chiropractic Adjustment: Serious complications to chiropractic treatment are rare. However, these may include fractures, disc injuries, dislocations, muscle strain, ligamentous sprain, and nerve injuries. Some patients may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The probability of serious complications occurring: Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, please tell your doctor and care steps will be taken to adjust your spine. Stroke has been the subject of much study and debate within the health professions. Manipulation of the neck has been associated with other injuries to the arteries in the neck leading to a stroke in rare instances. Studies have estimated this occurrence rate to be between 1 in 1 million to 1 in 3 million adjustments. To put this in perspective, your chances of being hit by lightning are reported to be 1 in 3 million. We employ tests in our examination, which are designed to identify possible risk factors for stroke, and we combine this with your medical history and our clinical skills to determine if you are a candidate for cervical manipulation. Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary to treat a disc injury. If necessary, we will refer you to a neurosurgeon or for an MRI exam. These problems are also rare with no reliable statistics to quantify their probability.

Ancillary treatments: In addition to chiropractic adjustments (manipulation of the joints), I intend to use the following treatments as needed to treat your condition:

- *Ice or Heat Packs: these may be used in the office or recommended for home use. Both may, in rare cases, irritate or burn the skin.
- *Myofascial release, Active Release Technique, and Trigger Point Therapy, which may, in rare cases, cause local bruising and soreness.
- *Electrical Stimulation: this therapy consists of a mild electrical current, which helps relax tight muscles, blocks pain, reduces swelling, and facilitates healing. There are no known side-effects other than discomfort if the settings are too high. At any time, if any of these procedures are uncomfortable, you are to notify the doctor and/or staff immediately and this procedure will be modified or discontinued.
- *Therapeutic and rehabilitative exercises, Active Release Technique, Neuromuscular Re-education, and Post Isometric Relaxation (PIR): these may be used to re-educate your muscles to restore normal functions and muscular balance. Every precaution is used to prevent injury. Injuries are rare and are usually from the patient "over doing it" or over stretching. Please follow your doctor's recommendations carefully.

Initial: _____ Date: _____

Alternative Medical Treatment Risks are:

- *Self-administered over the counter NSAIDS may cause gastro-intestinal problems and bleeding of liver and kidney disease i.e: Aspirin, Ibuprophen, Aleve, etc.

- *Prescription muscle relaxants and painkillers can produce undesirable side effects and addiction. They can also make you drowsy and impair your motor skills.

- *Hospitalization and bed rest has the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% per day. It is very expensive, and research has shown bed rest has no benefit in helping back pain patients. In fact, it may make your condition worse.

- *Back or neck surgery poses many risks, such as: infections, allergic reactions, disfiguring scars, severe loss of blood, loss of function of any limb, organ paralysis, paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder; bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; unstable spine requiring fusion; and infection.

- *Injections of pain medications: The risk inherent in using injections or surgery included adverse reactions to anesthesia or the injected medication, iatrogenic (caused by a doctor) problems, hospitalization and possible convalescent time.

The Risks and Dangers of Remaining Untreated: Remaining untreated allows the formation of adhesions and reduced joint motion, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage and muscle weakness may progress if your spinal problem goes untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

I have read, or have had read to me, the above information. I have had an opportunity to ask my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment in this office. Having considered the nature and risks of chiropractic care, I hereby give my consent to be treated.

_____	_____	_____
Patient's Name (Printed)	**Patient Signature**	**Date**

***If you are a minor, or if you are being represented by another party:**

_____	_____	_____
Name of Parent or Guardian (printed)	**Signature of Parent or Guardian**	**Date**

Witness:

_____	_____	_____
Name of Witness (Printed)	**Signature of Witness**	**Date**

Akers Chiropractic

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:

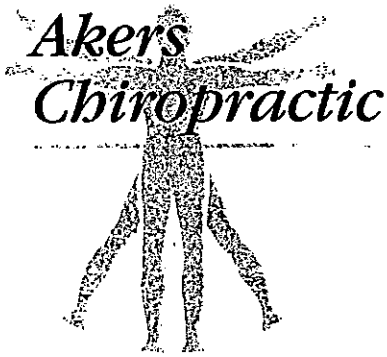
1. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered 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: _____