Health Concepts I ..... Client Information

In order to provide you the best possible care, please complete this form. All information is confidential.

Patient Data

Name_____ DOB_____ Sex: M F

Social Security #_____ Marital Status _____

Address_____ City_____ State ____ Zip _____

Phone: Cell_____ Home_____ Email_____

Occupation_____ Employer_____ Student_____

Spouse_____ Occupation_____ Employer_____

Type of Case: Auto_____ Workers Comp_____ Insurance_____ Self Pay _____

If Female: Date of last menses _____

Do you smoke _____ Ethnicity: Hispanic Latino Other _____

Race: White African American Alaskan Native Asian Hawaiian Pacific Islander decline to answer

Medications : _____

Allergies:_____

Vitamins or Supplements _____

Emergency Contact _____ Phone _____Referred by _____

Current Condition

Date Symptoms appeared _____ Date Injury occurred _____

Has this occurred before: Y N If yes..when?_____

Practitioners seen for this condition before?_____

Hospitalization for current condition _____ Have you been unable to work_____

Do you have pain every day_____ Does this interfere with daily life _____

When is your pain worst_____ What aggrevates your condition_____

Have you had X-rays taken for this condition _____ X-rays in the last year?_____

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Medical History

Date of last physical exam_____ If female is there any chance you are pregnant:_____

Broken Bones_____ Previous Auto Accidents_____

Previous Hospitalizations_____

Previous Surgeries_____

Previous or Current Medical Conditions _____

Family History

Please list Family member and condition: _____

_____

Our goal at HCI is to bring your body into balance structurally, emotionally and nutritionally. This will allow your body to achieve its optimum health and well-being. Any lack of these areas will lead to dis-ease in your body.

I understand that the doctor is a chiropractor and not a medical doctor and that testing procedures, therapies, or suggestions do not replace or intend to replace medical treatments or procedures. Our focus at this office is health and wellness and promoting the body to heal itself. We do not claim that any interventions "cure" any disease. We address the body and the patient as a whole and **do not** treat any disease or condition.

Some of the testing procedures available at this office are Body Scan and Thermography. These tests are opportunities to get and use extra information to help identify stresses in the body. The evaluations may include recommendations for natural remedies or supplements, stress reduction methods, and / or nutritional changes designed to balance the energy meridians and enhance overall wellness as well as referrals to other healthcare practitioners. No recommendation made by a doctor at this practice is a cure for any known disease, nor have they been proven clinically to eliminate any specific disease process. None of our recommendations are replacement for any medication or treatment currently being provided or recommended by an allopathic physician.

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1) I fully understand that the chiropractor is not a licensed medical doctor. The chiropractor is not providing any type of allopathic services but is making suggestions that are within the natural health and wellness philosophy.

2) I fully understand that the chiropractor will not offer drugs, surgery, chemical stimulants, or radiation therapy, but is providing information and natural products to restore natural balance and optimum conditions for health and wellness.

3) I fully understand that the chiropractor is not diagnosing or treating any illness or disease, but is measuring the Bio-energetic balance and overall stress the body and that these services may not be generally accepted and/or recommended by allopathic physicians.

4) I understand the chiropractor is in no way encouraging me to terminate or modify any previous or ongoing therapies or treatments under the direction of any licensed practitioner and that the chiropractor cannot and will not dissuade me from seeking medical attention, recommendation or therapy.

5) I presently seek consultation, advice, opinion and or programs , tests, evaluations and/or products of a wellness practice based upon principles of holistic health and have willingly solicited these services in good faith, exerting free will and following the dictates of my own conscience which allow me to select what I understand to be beneficial to my health

6) If a minor or incompetent person is with me, I give full faith that I am legally and totally responsible for them and have legal right to make decisions for them.

7) I authorize the chiropractor to provide services to me on my behalf, and hereby release her/him from any and all claims and potential claims arising out of my actions or failure to act upon his/her advice.

8) I give full faith that I have read and understand this document entirely.

I hereby consent to and authorize the above-described consultation, evaluation and health program

Client Signature_____ Date_____

Parent or Guardian if client under 18 _____

Witness _____ Date_____

Witness did patient verbally confirm reading this form entirely? _____

CANCELLATION / RESCHEDULING POLICY

Health Concepts I, is a waiting list practice and certain treatments and/or tests take a full hour of the doctor's time. Therefore, Health Concepts I, **requires a 24 hour (1 day) cancellation notice which if not given wil result in the follow cancellation fees:**

Body Scan / Body Scan Retest	**$75.00**
Chiropractic Visit	**$25.00**
Massage	**$50.00**

No Show Massage appointment without any notice will be charged at the full price for the service. (35.00/ $70.00)**

If excessive cancellations occur, Health Concepts I will require a $25 to $75 deposit (depending on type of appointment) upon scheduling future appointments with a credit card guarantee on file.

I have read and understand the financial policy of Health Concepts I. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Health Concepts I and my insurance company. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors, that I am ultimately responsible for any reduced or unpaid services and fees will be due and payable immediately.

_____

Print Patient Name (or guardian if patient is a minor) Date

_____

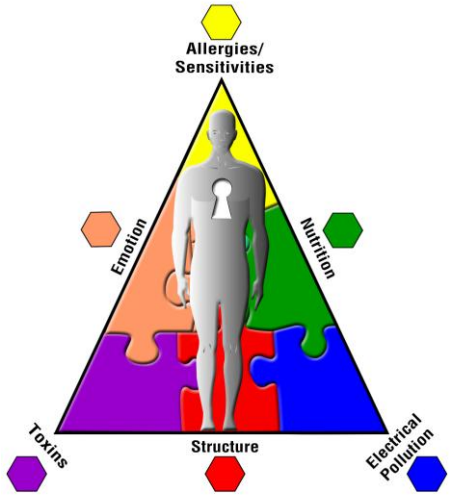
Patient's signature (or guardian if patient is a minor) Date

_____

Witness Date

Health Concepts I, LLC
FINANCIAL POLICY

Total Body Wellness!



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SERVICES & FEES

We request that 100% of your visit including herbs and/or supplements be paid at the time of service. All fees are based upon individual services rendered and may vary from visit to visit depending upon the doctor's specific recommendations. Fees are subject to change.

_____Initial

"SELF-PAY" PATIENTS

Several options are available for self pay patients. These options will allow you and the doctor to tailor your treatment to best fit your specific needs without being restricted by insurance limitations. These options will be discussed with you early in your care. If you do have insurance but choose to be a self pay patient, you will make this election in writing and for a period of 12 months. No changes can be made during the 12 month agreement for any reason. Supplements or supplies are not included in any packages. We are happy to accept cash, checks and all major credit cards. Payment is expected the day of service. **Any outstanding balance that is greater than 30 days past due can be subject to late fees or a percentage per month or both until paid in full**.

_____Initial

GROUP OR INDIVIDUAL INSURANCE

Some chiropractic services can be covered by your health insurance. Most services at our office however, are not covered by insurance. Uncovered services include: Body Scan, Thermography, Massage, Laser, Energy therapies, Supplements, Nutritional consultations and supplies. We will call to verify benefits on your insurance. The benefits quoted to us by your insurance company are **not a guarantee** of payment. Insurance claims will be filed as services are rendered and we will make every effort to receive payment from your insurance company**. However, you are ultimately responsible for any reduced or unpaid services.** Payment will be due by you at the time of service for any non-covered services, deductibles, co-insurances or co-pays. When we receive EOBs from your insurance we will bill you for any unpaid services or balance owed on your account. We are happy to accept check, cash or all major credit cards. **Any outstanding balance that is greater than 30 days past due can be subject to late fees or a percentage per month or both until paid in full**.

_____Initial

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. **If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees for services rendered are due by you immediately.**

_____Initial

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. **Although you are ultimately responsible for payment for your account, we may wait for settlement of your claim for up to three months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services rendered are due by you immediately.**

_____Initial

MEDICARE

Please be aware that medicare or secondary insurance will only cover spinal adjustment charges. To receive these benefits you must pay your deductible if it has not been met and an exam charge. No other services provided at this office are covered by medicare or secondary insurance and will be your responsibility. If you do not have a secondary insurance you will be responsible for your deductible, copay and any other charges due. Our office completes and files the forms for Medicare at no additional charge to you. Payment for your charges is expected at the time of service**. Any outstanding balance that is greater than 30 days past due can be subject to late fees or a percentage per month or both until paid in full.**

_____Initial