Avé Holistic Health & Chiropractic

3601 Minnesota Dr. Suite B. Anchorage, AK 99503
Phone: 907-770-1255 Fax: 907-770-1256

Patient Name: ______________________________ Date of Birth: ___________________
SSN: ________-_______-__________ Sex at Birth: Male or Female

Mailing Address: ______________________________ City: __________________________
Physical Address: ______________________________ State: _____________ Zip: ________

Email: ____
Home Phone: ________________ Cell: __________________ Work: ___________________
May we leave a voicemail? Yes or No
Appointment Reminder Preference: Text or Email

Employer: _______________________________ Occupation: __________________________
Parent/Legal Guardian (if not patient): ____
Marital Status: Married / Single / Widowed / Divorced / Domestic Partner
If applicable, partner's name: _________________________ May we contact? Yes or No

How did you hear about us? ____

Emergency contacts:
Name: _____________________ Phone: _________________ Relationship: _______________
Name: _____________________ Phone: _________________ Relationship: _______________

INSURANCE INFORMATION:

Primary Insurance
Policy Holder: __________________________ Insurance Company: __________________
Holder's Date of Birth: _____/_____/_________ Policy Number: ______________________
Holder's SSN ______-______-_________ Group Number: ______________________
Holder's Employer: ______________________ Insurance Phone: _____________________

Secondary Insurance
Policy Holder: __________________________ Insurance Company: __________________
Holder's Date of Birth: _____/_____/_________ Policy Number: ______________________
Holder's SSN ______-______-_________ Group Number: ______________________
Holder's Employer: ______________________ Insurance Phone: _____________________

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HIPAA PRIVACY ACCEPTANCE

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF part 164 (the "Security Rule", "Breach Notification Rule", and "Privacy Rule") as well as the Alaska Personal Information Protection Act found under AS45.48. I have certain rights to privacy regarding my Protected Health Information (PHI).

I understand the information can and will be used for the following:

1) Conduct, plan and direct my treatment and follow-up among health care providers
2) Obtain payment from 3rd party payers 3) Conduct normal healthcare operations

We hold your PHI to the highest standards in this office, however, dialogue between the patient and office staff may be heard by other parties not bound by HIPAA rules and regulations. Additionally, for the safety and security of our patients and staff, we use CCTV monitoring in public use areas only. There is no recording of any type at any time. If you have concerns you feel uncomfortable discussing in our office environment, we can always address those concerns in a private setting. You also have the option to review this clinic's Notice of Privacy Practices (NPP) containing a more complete description of the uses and disclosures of PHI. This organization has the right to change its NPP from time to time, and you may contact this organization at any time at the address above to review a current copy.

OFFICE POLICIES

Avé Holistic Health & Chiropractic imposes a $60 flat fee for any missed appointments.

We will send a reminder the day before your appointment via text message or email. If you need to cancel and would like to avoid the late-cancellation fee, please text, call, or email at least 12 hours in advance. If we are out of the office, please leave a voicemail. If you are a VA patient, our 3-appointment policy applies.

As a courtesy, we will check your insurance coverage before your appointment.
Ultimately, your insurance policy is a contract between you and the insurance company.
It is your responsibility to be aware of your benefits and coverage.

By signing below, I understand that Avé Holistic Health & Chiropractic (AHHC) will bill my insurance company (if applicable), and I am responsible for any co-pay, co-insurance, deductible, non-covered items or services deemed not medically necessary by my insurance company. I authorize AHHC to release medical records required by my insurance company at any time. If upon review of those records, they find my treatment to be not medically necessary, I understand I will be responsible for the charges incurred.

I have read and understand the statements made in the Informed Consent for Chiropractic Care and therefore accept Chiropractic treatment in this office.

Printed Name: ______________________________ Signature: ________________________________

Date: ____________________

CONSENT TO EVALUATE & ADJUST A MINOR

I, ____________________, being the parent or legal guardian of ____________________, have read and fully understand the informed consent and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian Signature: ________________________________

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider including rights to any settlement insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2)submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

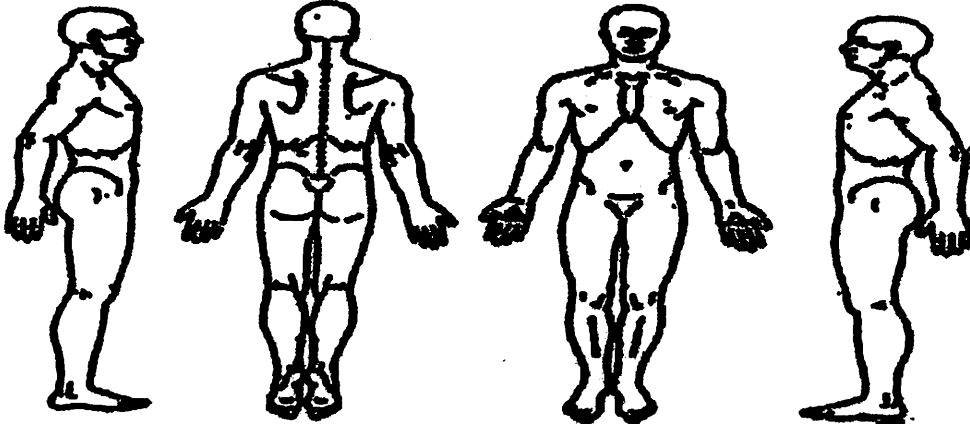
Patient Name:________________________________Date: ____________________

Patient Signature: ________________________________

AVÉ HOLISTIC HEALTH & CHIROPRACTIC
PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

1. Does today's visit fall under either category? Circle if applicable:
   Auto Insurance Claim   Worker's Compensation Claim
2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - □ Constantly (76-100% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51-75% of the time)
   - □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - □ Sharp
   - □ Numb
   - □ Dull
   - □ Tingly
   - □ Diffuse
   - □ Sharp with motion
   - □ Achy
   - □ Shooting with motion
   - □ Burning
   - □ Stabbing with motion
   - □ Shooting
   - □ Electric like with motion
   - □ Stiff
   - □ Other:__________________

5. How are your symptoms changing with time?
   □ Getting Worse   □ Staying the Same   □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
   □ Not at all   □ A little bit   □ Moderately   □ Quite a bit   □ Extremely

8. How much has the problem interfered with your social activities?
   □ Not at all   □ A little bit   □ Moderately   Quite a bit   □ Extremely

9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ Neurologist
   - □ Primary Care Physician
   - □ ER physician
   - □ Orthopedist
   - □ Other:____________
   - □ Massage Therapist
   - □ Physical Therapist
   - □ No one

10. How long have you had this problem? __________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?
    □ Yes   □ Yes, at times   □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height__________ Weight ____________ Date of Birth __________
Occupation ____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:______________				

20. List all prescription medications you are currently taking:
____

21. List all of the over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had:
____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?________________________

Patient Signature________________________ **Date:**______________

Patient's Name:____Date:______________________________

FUNCTIONAL RATING INDEX

For Neck and/or Back Problems only: Please circle the number which most closely describes your condition *right now*.

Section 1 - Pain Intensity

0) No pain
1) Mild pain
2) Moderate pain
3) Severe pain
4) Worst possible pain

Section 2 – Sleeping

0) Perfect sleep
1) Mildly disturbed sleep
2) Moderately disturbed sleep
3) Greatly disturbed sleep
4) Totally disturbed sleep

Section 3 - Personal Care (Washing, Dressing, etc.)

0) No pain; No restrictions
1) Mild pain; No restrictions
2) Moderate pain; Need to go slowly
3) Moderate pain; Need some assistance
4) Severe pain; Need 100% assistance

Section 4 - Traveling (driving, etc.)

0) No pain on long trips
1) Mild pain on long trips
2) Moderate pain on long trips
3) Moderate pain on short trips
4) Severe pain on short trips

Section 5 - Work

0) Can do usual work plus unlimited extra work
1) Can do usual work but *no* extra work
2) Can do 50% of usual work
3) Can do 25% of usual work
4) Cannot work

Section 6 - Recreation

0) Can do all activities
1) Can do most activities
2) Can do some activities
3) Can do a few activities
4) Cannot do any activities

Section 7 - Frequency of Pain

0) No pain
1) Occasional pain; 25% of the day
2) Intermittent pain; 50% of the day
3) Frequent pain; 75% of the day
4) Constant pain; 100% of the day

Section 8 - Lifting

0) No pain with heavy weight
1) Increased pain with heavy weight
2) Increased pain with moderate weight
3) Increased pain with light weight
4) Increased pain with any weight

Section 9 - Walking

0) No pain; Any distance
1) Increased pain after 1.0 mile
2) Increased pain after 1/2 mile
3) Increased pain after 1/4 mile
4) Increased with all walking

Section 10 - Standing

0) No pain after several hours
1) Increased pain after several hours
2) Increased pain after 1 hour
3) Increased pain after ½ hour
4) Increased pain with any standing

Patient Specific Functional and Pain Scale

Name:______________________________ DOB:______________
Provider Name:______________________________ Date:______________

Patient Instructions:
Please list and score at least 3 activities that you are having the most difficulty with, or are unable to perform, due to your chief problem.

Patient Specific Activity Scoring Scale:

0 = unable to perform activity	0	1	2	3	4	5	6	7	8	9	10	10=Able to perform activity at same level as before injury or problem

Activity	**Patient Specific Activity Scoring Scale**
Ex: walking up stairs	0 1 2 3 (4) 5 6 7 8 9 10
1.	0 1 2 3 4 5 6 7 8 9 10
2.	0 1 2 3 4 5 6 7 8 9 10
3.	0 1 2 3 4 5 6 7 8 9 10
4.	0 1 2 3 4 5 6 7 8 9 10
5.	0 1 2 3 4 5 6 7 8 9 10

Signatures:

I understand that the information I have provided above is current and complete to the best of my knowledge.

Patient (age 18 or older:)______________________________ Date:______________
Patient/Guardian (if under age 18): ______________________________ Date:______________