PATIENT INFORMATION

Gender: □ Male □ Female Title: □ Mr. □ Ms. □ Mrs. Suffix: Sr. □ Jr. □ Other_

Last Name:_____First Name:_____D.O.B.___/___/_____

Address :_____City:_____State /Zip: _____

Race: □ African American □ American Indian □ Asian □ Black □ Native Hawaiian □ Pacific Islander □ White

□ Hispanic or Latin □ Not Hispanic or Latin

Marital Status: (Circle One) S M D W Preferred Language: □ English or □ Spanish

S.S. #_____-____-_____Employer:_____Employer Phone #: (_____)_____-_____

E-Mail:_____@_____.com Home #: (_____)_____-_____

Work #: (_____)_____-_____Cell #: (_____)_____-_____ ***Circle preferred method of contact**

Spouse's Name: _____ Spouse's S.S. #____-___-_____ Spouse's D.O.B. ___/___/___

Spouse's Employer _____ Spouse's Cell # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency_____Phone (_____)_____-_____

Name of person responsible for account_____Relationship to patient_____

Insurance Information

Name of insured_____Relationship to Patient _____

Birthdate _____/_____/_____ SS#_____-_____-_____ Name of Employer _____

Insurance Company_____ID#_____Group# _____

Do you have a deductible? □ Yes □ No If yes, how much is it? $_____ How much have you met? $_____

DO YOU HAVE ADDITIONAL INSURANCE? □ Yes □ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured_____Relationship to Patient _____

Birthdate_____/____/_____ SS#_____-_____-_____ Name of Employer _____

Insurance Company_____ID#_____Group# _____

Do you have a deductible? □ Yes □ No If yes, how much is it? $_____ How much have you met? $_____

Patient Condition

Reason for Visit_____When did your symptoms appear? _____

Is condition due to an accident? □ Yes □ No Type of Accident □ Auto □ Work

Date of Accident _____

Is this condition getting progressively worse: □ Yes □ No □

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

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Shooting

□ Aching □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other How

often do you have this pain? _____

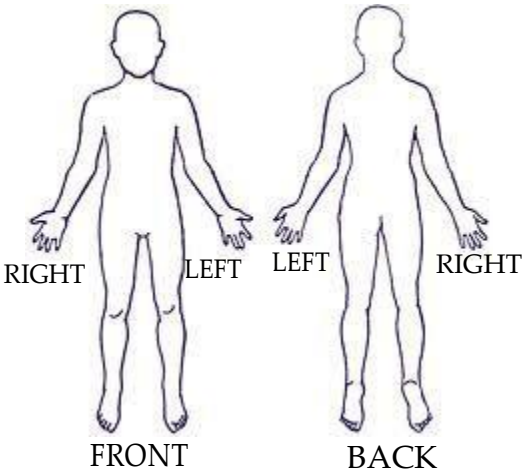
Is this pain constant or does it come and go? _____

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform?

□ Sitting □ Standing □ Walking □ Bending □ Lying Down

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



Health History

What treatment have you already received for you condition? □ Medication □ Surgery □ Physical Therapy □ Chiropractic Services

□ None □ Other _____

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

*Please check only those conditions which are applicable: *Note if it applies to a family member.*

□ AIDS/HIV	□ Cataracts	□ Hepatitis	□ Osteoporosis	□Suicide Attempt
□ Alcoholism	□ Chemical Dependency	□ Hernia	□ Pacemaker	□ Thyroid Problems
□ Allergy shots	□ Chicken Pox	□ Herniated Disk	□ Parkinson's Disease	□ Tonsillitis
□ Anemia	□ Depression	□ Herpes	□ Pinched Nerve	□ Tuberculosis
□ Anorexia	□ Diabetes	□ High Cholesterol	□ Pneumonia	□ Tumors, Growths
□ Appendicitis	□ Emphysema	□ Kidney Disease	□ Polio	□ Typhoid Fever
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Prostate Problems	□ Ulcers
□ Asthma	□ Fractures	□ Measles	□ Prosthesis	□ Vaginal Infections
□ Bleeding Disorders	□ Glaucoma	□ Migraine Headaches	□ Psychiatric Care	□ Venereal Disease
□ Breast Lump	□ Goiter	□ Miscarriage	□ Rheumatoid Arthritis	□ Whooping Cough
□ Bronchitis	□ Gonorrhea	□ Mononucleosis	□ Rheumatic Fever	□ Other _____
□ Bulimia	□ Gout	□ Multiple Sclerosis	□ Scarlet Fever	_____
□ Cancer	□ Heart Disease	□ Mumps	□ Stroke	_____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Please list any types of surgeries that you have had and the dates on which they occurred: _____

_____

What medications are you currently taking? _____

What vitamins are you currently taking? _____

What kind of other nutritional supplements, if any, are you currently taking? _____

Please list any allergies to medication: _____

What type of exercise do you perform on a daily basis? □ None □ Light □Moderate □ Heavy

What do your daily work habits include? □ Sitting □ Standing □ Light Labor □ Heavy Labor

Do you smoke? □Yes □No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health, this information, or health insurance.

I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr. Berg 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 pay 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.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

NORTH HILLS CHIROPRACTIC, INC.

208 Lemmon Drive
Reno, Nevada 89506
Phone: (775) 972-4488
Fax: (775) 972-1853

Privacy Policy

Our office is fully committed to compliance with HIPAA guidelines by:

1. Providing appropriate security for our patients records
2. Protecting the privacy of our patients' medical information
3. Providing our patients with proper access to their medical records, one a signed release is obtained.
4. Appropriately maintaining our patients information and billing process in compliance with National HIPAA standards
5. NOT providing patients' data to marketers or pharmaceutical companies for the purpose of research

I acknowledge that I have read and understand the privacy policy of North Hills Chiropractic, Inc.

_____ _____

Patient/Legal Guardian Signature Date

_____Please be advised that pursuant to Federal Law, your medical records will be kept for 5
Initials years, after which, they may be destroyed.

Yes____No____Can messages be left on your answering machine, voicemail, or with family members?

Please list the alternate phone number that you which to receive calls about appointments, billing issues, or any other information, if you do not wish to be contacted at home.
*Preferred Alternate Phone Number:*_____

*** If left blank, we will assume it is okay to call your home phone number and also leave messages for you ***

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Financial Agreement

North Hills Chiropractic and the Doctors participate in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by North Hills Chiropractic will be submitted directly to your insurance company for payment, as a courtesy to you. All copays and deductibles are due at the time of service. We will try our best to notify you of your financial obligations at the time of your visit, but it is ultimately your responsibility to know and pay your financial obligations. **Copays and/or deductibles collected upfront are an estimated amount. You will be responsible for any amount not paid by your insurance.**

Should you not have insurance coverage, you will be considered a self-pay patient. We offer discounted rates and you will be responsible for paying the total charges at the time of your visit.

*** Patients should note that not all Chiropractic procedures, exams and/or modalities are covered by insurance. Patients may be directly responsible for such fees. We will do our best to inform you of your benefits at the time of your visit.

*** It is your responsibility to notify our office if prior authorization/referrals are required.

*** **Please be aware that our office has a 24-hour cancellation policy.** You will be charged a fee of $20 for every appointment that is broken without giving 24 hour notice. 24 hour notice can be given when we are closed, such as on the weekends, by simply leaving a message on our voicemail 24 hours prior to your appointment time.

Authorization

I authorize North Hills Chiropractic, Dr. David D. Berg, DC., to release any information acquired during my exam and treatment for the purpose of claim payment. I further authorize payment directly to the doctor for benefits due to me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

Patient Name Social Security #

Signature Date

Goals For My Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction in their bodies for what is malfunctioning. Your doctor will weigh your needs and desires when recommending your treatment program.

- ACUTE CARE
  Initial intensive care is given for aches, pains or other obvious symptoms that have prompted you to seek treatment. Treatments will consist of gentle adjustments, using ice on the affected areas, and electric muscle stimulation. We may ask you to decrease activities that aggravate your condition. Treatments will be done 2-3 times per week for 3-4 weeks.

- SUB-ACUTE CARE
  This phase of treatment consists of more aggressive adjustments along with electric muscle stimulation, and range of motion exercises, and heat therapy. Treatments in this phase will normally be done 1-2 times per week for 2-6 weeks.

- REHABILITIVE CARE
  Muscles and other soft tissue damage often remain after your original symptoms have improved. Rehabilitative care stabilizes your spine and promotes more complete healing. Treatments include strengthening and stabilization exercises, aggressive stretching and correction of muscle imbalances. The visits are usually 2-4 times per month.

- MAINTENANCE/WELLNESS CARE
  When maximum medical improvement has been reached, periodic "check-ups" are recommended. These wellness visits can detect and help correct new problems before they become serious. Wellness visits occur normally once every 1-3 months and include re-examinations, adjustments, and counseling for diet, nutrition and exercise.

Patient Signature _____ Date_____

Dr. Recommends: _____ times for the next _____weeks

_____ times for the next _____weeks

_____ times for the next _____weeks

_____ times for the next _____month

Informed consent for chiropractic treatment

To the patient: you have the right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures. The chiropractic treatment may be performed by the doctor and/or staff.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

*Broken bones	*Increased symptoms and pain
*Dislocations	*No improvement of symptoms or pain
*Sprains/strains	*Stroke
*Burns or frostbite	* Worsening/aggravation of spinal conditions

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, and paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to have treatment. I intend this consent to cover the entire course of treatment for my current condition.

To be completed by patient	To be completed by staff or Doctor
_____	_____
Signature	Witness to patient signature
_____	_____
Date signed	Date signed