WELLNESS ONE
Patient History:

Name: _____ Who can we thank for referring you? _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail (please **print** clearly): _____

Social Security Number: _____ Medical doctor name: _____

Birthdate: _____ Sex: _____ Age: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer: _____

Emergency contact name and phone number: _____ Relationship: _____

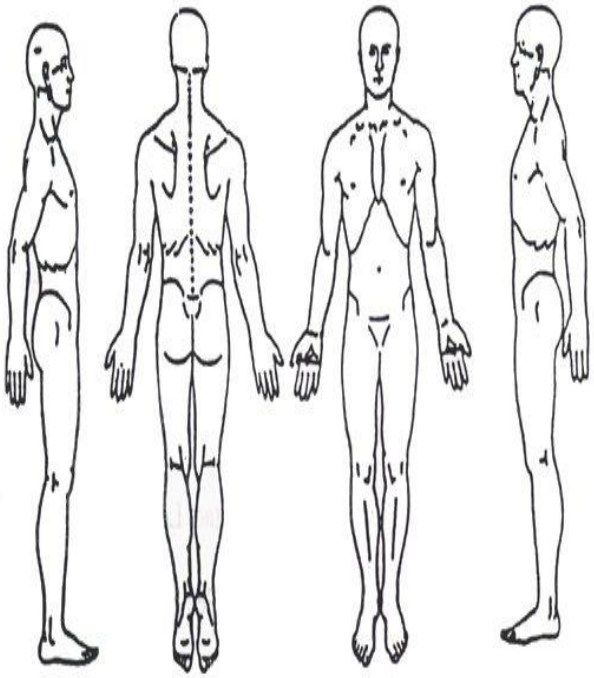
REMEMBER: ALL INFORMATION YOU GIVE IS CONFIDENTIAL

Major Complaints #1: _____
Major Complaints #2: _____
Major Complaints #3: _____
Family history of (circle): Heart disease High blood pressure Cancer Diabetes Stroke other _____
How long have has your current complaint(s) bothering you? _____
What makes it better?_____ What makes it worse?_____
Have you missed any work due to this? Yes / No If so, how much? _____
Have you had these symptoms in the past? Yes / No When? _____
Have you ever been to a chiropractor? Yes / No How often does this bother you?_____

PLEASE CHECK THE BOXES AND MARK THE PAINFUL AREAS
(Use *Quality* Key Below)

Past	Present	Condition
O	O	Headaches
O	O	Migraines
O	O	Arthritis
O	O	Allergies / Asthma
O	O	Anemia
O	O	Joint pain
O	O	Depression
O	O	Irritability
O	O	Sinus problems
O	O	Bruise easily
O	O	Frequent colds
O	O	Fatigue / low energy
O	O	Trouble sleeping
O	O	Shortness of breath
O	O	Chest pain / tightness
O	O	Anxiety
O	O	Dizziness
O	O	High blood pressure
O	O	Recent vision changes
O	O	Vertigo
O	O	Infectious diseases
O	O	Prostate problems
O	O	Uterus problems
O	O	Pregnancy
O	O	Pacemaker
O	O	Increase urination
O	O	Tobacco / nicotine use

Quality
S= Sharp
A = Achy
T=Tight
St = Stiff
B = Burning
D = Dull
R = Radiating



How would you like to have your problem handled? (check which one)

O Temporary Relief: Help the symptom, but do not fix the underlying cause of the problem.

O Maximum Allowable Correction: Correct the underlying cause while optimizing my future health.

Why did you choose this office and what are "your" expectations?

_____
_____

On a scale from 1-10: (10 being the most and 1 being the least)
How committed are you from the following?

_____ Being at your maximum health potential.
_____ Your family to be at their maximum health potential.
_____ Preventing spinal arthritis.
_____ Preventing degenerative disc disease.
_____ What is your pain level today?

Check if you have had the following surgeries: (what kind and when?)

O Spine _____
O Hip _____
O Knee _____
O Foot / Ankle _____

List medications and supplements you currently take (prescription and over the counter): _____

_____
_____

Who else have you seen for this condition? (check and circle)

O Family doctor / PA / Nurse
O Orthopedic / Neurologist
O Physical therapist
O Chiropractor
O Massage therapist
O Other _____

AUTHORIZATIONS: (I agree)

Dr. Charlie Gray, D.C. (Wellness One) can release, or request records as needed for my care.
I authorize assignment of any insurance benefits (if applicable) paid directly to the provider.
I authorize the staff and/or doctor to render care as deemed appropriate for me, my child, or my children.
After (if) any initial promotional offers, fees are rendered at usual and customary. Fees due are available upon request.
I am responsible for all the charges incurred at this office, this includes any late fees, collections fees, attorney fees, small claims fees, interest added, and/or any fees necessary for non-payment. Any insurance benefits are never a guarantee of payments.
I authorize this office to send my x-rays to any radiologist for an additional review and report. Any x-rays reviewed by any third party is at the expense of the patient. Not all x-rays are sent for review.

Please feel free to discuss all of our fees with us as it relates to your care. Fees are payable when services are rendered unless other arrangements are made in advance. Auto accidents, work injuries, and VA (Veteran's Administration) typically are not the patient's per visit responsibility at the time of service.

Signature: _____ Date: _____

Wellness One

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please choose 5 of your worst things you struggle with (functional deficits)

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Print Name:_____ **Patient DOB:**_____

Patient signature: _____ **Date:** _____

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Dr. Gray history: If you have any fears or concerns, please speak with me directly. With my 13+ years of chiropractic experience there has never been ANY incident of serious harm or injury. Chiropractic when done precisely is the safest form of healthcare.

I have read the explanation above. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo the treatment and hereby give my full consent.

Patient Print Name:_____ Patient DOB:_____

Patient Signature: _____ Date: _____

Please check which one applies to you

Typically, no insurance coverage is 100%, but if you have any benefits for chiropractic coverage for our office, we certainly will do everything we can to help your out of pocket expenses be as low as possible.

O **No Insurance:** Easy! Our care plans and simple payment plans have helped over thousands of people and will work great for you too!

O **Health Insurance / HSA:** Many insurances today pay very little or limited amounts for natural drugless care to get you healthy. We make it easy! We verify any benefits you have and file these claims directly to your insurance company. You are responsible for any deductibles, co-pays, co-insurance, and unpaid visits. For your convenience, all payment arrangements are made in advance.

O **Auto Injury:** Auto accidents are typically covered at 100%, even if you were at fault, not at fault, or were a passenger. You can get the care you need and it costs nothing. Great for you! All we need is a claim #, insurance information, and / or your attorney's information.

O **Work Injury:** Work injuries are covered 100% for between 12-24 visits. All we need is your claim # and worker's comp information.

O **Medicare:** Regardless of your condition, Medicare pays for a maximum of 12 weeks of care. They have strict rules and limitations and do NOT cover all office services. When benefits are exhausted, you are eligible for a significant discount.

O **VA (Veteran's Administration)**: We love helping our veterans. You will need a direct referral and authorization. Typically, 12 total visits are allowed per year. Certainly, this helps cover the cost of some of your initial care! VA does not cover all of our services.

Initial ___

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services at www.hhs.gov.
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handle appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payors in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to require restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, on this date _____, to hereby consent and acknowledge my agreement to the terms set forth in this HIPPA INFORMATION AND CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient _____

Policy holder's Employer _____
Policy Holder's DOB _____
Claim/Group # _____
SS/ID # _____
I hereby instruct and direct the _____ Insurance Company
To pay by check made out and mailed directly to:

Wellness One
36 14th Ave NE Suite 101
Hickory, NC 28601

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Dr. Charles Gray
36 14th Ave NE Suite 101
Hickory, NC 28601

I direct you to pay the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.
I also authorize the release of any medical information, or otherwise, pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____
Signature of policyholder Date

_____
Signature of claimant, if different than policyholder

Advantage Radiology Service

(419) 269-2424 (844) 283-4163

This form is for a third-party business, Advantage Radiology Service (ARS), that will review your x-rays if necessary, at the discretion of Wellness One, and prepare a report of their findings. This office, Wellness One, needs your permission to send your x-rays to this company for a thorough review and report. Their service is a complete and separate entity. Most insurances cover this charge. In the event that this fee is not covered, a small fee may be incurred. * A maximum of $ 37 would be incurred.

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to ensure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, VA, and/or to my attorney in the case of a personal injury. In the event that I receive a bill for these services, I agree to promptly remit payment to ARS.

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company attorney, and/or third part payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning their claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as describe above.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

Name:_____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____ Sex: _____ Age: _____