

ABOUT THE PATIENT

Dr. Joshua A. Cebula, 340 E. Lakewood Blvd. Holland, MI 49424

Legal Name _____ Preferred Name _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 DOB _____ Cell Phone _____ Gender M F
 Email Address _____ Sig. Other's Name _____
 Employer Name _____ Type of Work _____
 Have you been to a chiropractor before? No Yes If yes, how long ago? _____
 Name of *Medical* Dr. _____
 Emergency Contact/Relationship _____ Ph# _____
 Who can we thank for referring you in today? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize All About You Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

Patient / Parent Signature _____ (This represents a long term authorization for all occasions of service) _____ Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening **Pain Level:** 1 2 3 4 5 6 7 8 9 10

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening **Pain Level:** 1 2 3 4 5 6 7 8 9 10

3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening **Pain Level:** 1 2 3 4 5 6 7 8 9 10

4. Does your condition affect: Sleep Work Daily Routine Sitting Driving

5. What makes it better? _____

6. What makes it worse? _____

7. What Doctor's have you seen for this? _____

8. Type of treatment: _____

9. Results: _____

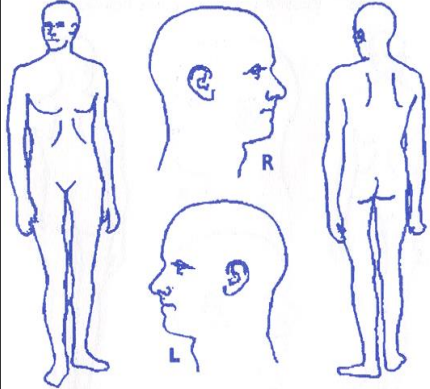
ANYTHING ELSE THE DR. SHOULD KNOW: _____

Are you pregnant?

Yes No

If yes, date due: _____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

- | Past | Present | Past | Present |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Migraines | <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> Hands or Feet cold | <input type="checkbox"/> | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Leg / Foot Numbness | <input type="checkbox"/> | <input type="checkbox"/> ___ High or ___ Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> | <input type="checkbox"/> Pain all Over |
| <input type="checkbox"/> | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> | <input type="checkbox"/> Tension / Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Light Bothers Eyes | | |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ | | |

- List any medications you are taking: _____
- Please list all doctors you are currently seeing: _____
- Has any Doctor or other professional advised you to "Go to a Chiropractor ": No Yes, Name _____

PAST HISTORY

- List any past auto collisions: _____ Was any care received? _____
- List any past work injuries: _____ Was any care received? _____
- List any past sport, recreational, or home injuries _____
- Please describe any past conditions and treatment received: _____
- Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

- Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____
- Is there any other family history you want us to know? _____

HIPPA PRIVACY PRACTICES

I acknowledge that All About You Chiropractic, LLC "Notice of Privacy Practices" has been made available to me. I understand I have the right to review All About You Chiropractic's Notice of Private Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at All About You Chiropractic, LLC.

The Notice of Privacy Practice is also posted on our website at www.aaycholland.com. It is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and All About You Chiropractic, LLC's duties with respect to my protected health information. All About You Chiropractic, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Please list below the names of person(s) authorized to gain access to patient account information:

INFORMED CONSENT

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. The doctors are aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should let us know when we take your clinical history.

Print Name: _____ Signature: _____ Date: _____
(Name of Patient/Patient Representation)

ACKNOWLEDGMENT OF UNDERSTANDING

By signing below, I acknowledge that I have been provided a copy of the All About You Chiropractic Clinic Policies and Payment Policy. I have also been notified of the HIPAA Policy and Privacy Practices utilized in this office. Copies are posted on our website at www.aaycholland.com. It is also provided upon request at the main administration desk.

I understand that I am financially responsible and agree to pay any health insurance deductibles, co-insurance, co-pays, and amounts not covered by insurance or Medicare. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as agency fees, court costs, and attorney fees.

My signature also authorizes the payment be made directly to All About You Chiropractic for any and all insurance benefits or reimbursements for services rendered by this company as well as authorizes the release of information concerning my health and health care services to my insurance companies, health plan or Medicare.

I understand and agree that All About You Chiropractic has the right to refuse to accept me at any time before treatment begins. (A consultation and the conducting of a physical evaluation are not considered treatment.)

I authorize the staff of All About You Chiropractic to perform any necessary services needed during diagnosis and treatment. I also certify that no guarantee has been made as to the results that may be attained through such treatment.

I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient/Patient Representation

Date

Paying for your care is easy here!

Mark and initial which one is you:

No Insurance :

- Easy! Our Care Plans and simple payment arrangements have helped over 2,000 people and will work great for you too!

Initial _____

Health Insurance:

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- You pay us. We will send any insurance claims in for you at no charge. If they pay anything after your deductible, or co-ins and copays are met, the money will go directly to you.
- Of course you can use your HSA, HRA, and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial _____

Auto Injury:

- Auto related injuries are covered **100%** in Michigan. Even if you were at fault or were a passenger. You can get the care you need and it costs you \$0. Great for you! (*Deductible may apply*)
- All we need is your claim number and insurance company.

Initial _____

Work Injury:

- Work Injuries are covered 100% for up to 12 weeks of care.
- All we need is your claim number and Work Comp ins. info.

Initial _____

Medicare:

- Regardless of your condition, Medicare pays for up to a maximum of 18 weeks of care. They have very strict rules and limitations.
- After this, you will receive a significant Medicare discount.

Initial _____