Phone: 402-318-5797

8550 Andermatt Drive, Suite 2

Lincoln, NE 68526

www.expresslifechiropractic.com

CONFIDENTIAL PATIENT INFORMATION

First Name: | Last Name: | Date of Birth: | Age:

Gender: ○ M ○ F | Social Security Number: | Height (ft, in): | Weight (lbs):

Street Address:

Apt./Unit#: | City: | State: | Zip Code:

Cell Phone: | Other Phone: | Email: | Preferred Method of Contact:

Your Occupation: | Employer's Name:

Do you currently or have you served in the Military?
○ Yes ○ No

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed

Name of Spouse:

# of Children:

Names, Ages, & Genders of Children:

How did you hear about us?

Emergency Contact: | Emergency Relation: | Emergency Phone:

Primary Insurance Carrier: | Name of Insured:

Insured Date of Birth: | Insured Social Security Number:

Secondary Insurance Carrier: | Name of Insured:

Insured Date of Birth: | Insured Social Security Number:

Who is your Primary Care Physician?

Date of your last visit:

Reason for your last doctor visit:

CURRENT HEALTH CONDITIONS

What primary health concern brings you into our office?

When did this condition first begin?

How did this problem start?

Is this condition:

How often is this present?

Severity:

Have you received care for this problem before?

○ Yes ○ No

How would you describe this problem?

☐ Sharp ☐ Dull ☐ Ache ☐ Sore ☐ Spasm ☐ Numbness ☐ Tingling ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stiff ☐ N/A

What makes the problem better?

What makes the problem worse?

Quadruple Visual Analogue Scale

Indicate your pain on a scale of 1-10, 1 being no pain and 10 being worst possible pain.

What is your pain RIGHT NOW?

What is your TYPICAL or AVERAGE pain?

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

What is your pain level AT ITS WORST (How close to 10 does your pain get at its worst)?

What other healthcare providers are you currently seeking care from for this condition?

	Name	Specialty
1		
2		

Our Doctors will recommend care for you based on 2 things...

1. The Doctors findings from your first visit

2. YOUR health and/or daily living goals

Please describe what your immediate, short-term, and long-term goals are so our doctors can put the best plan in place for you.

1. What are your immediate goals?

2. What are your short-term goals?

3. What are your long-term goals?

What would you like to gain from chiropractic care?

○ Resolve existing challenge ○ Overall wellness ○ Both, reach my health goals and achieve overall wellness

Have you ever visited a chiropractor before?

○ Yes ○ No

If yes, which practice(s)?

When was your last visit?

How often did you receive care?

○ Every Week ○ Every Other Week ○ Every Month ○ Only When It Hurt

How are your symptoms/conditions interfering with your life? (select all that apply)

☐ Affects my work/ability to work ☐ Cannot exercise like I want ☐ Limits my hobbies or recreational activities

☐ Affects my relationships ☐ Affects my sleep and rest ☐ I struggle to take care of myself ☐ Affects my energy levels

☐ Limits my productivity or creativity ☐ Impacts my attitude and patience

How committed are you to correcting the underlying issues?

	Other Health Concerns	Severity (1-10)	How long have you had this?	Did this start with an injury?	Have you had this before?	Constant or Comes/Goes
1						
2						

TRAUMAS: Physical Injury History

Have you ever had any significant falls, injuries, or surgeries as an adult?

○ Yes ○ No

If yes, please explain:

Any auto accidents?

○ Yes ○ No

Please list (include type and year):

Did you participate in any youth or college sports?

○ Yes ○ No

Please list any major injuries:

Notable childhood falls, injuries, or surgeries?

○ Yes ○ No

Please explain:

TOXINS: Chemicals & Environmental Exposure

Please list any medication you are taking and reason for taking it.

	Medication	Reason	Date Started
1			
2			

Please list any vitamin/supplements and the reason for taking it.

	Vitamin/Supplement	Reason
1		
2		

THOUGHTS: Emotional Stresses & Challenges

Please rate your stress for each:

	1- None	2- Moderate	3- High
Home	○	○	○
Work	○	○	○
Life	○	○	○
Money	○	○	○
Health	○	○	○
Family	○	○	○
Other	○	○	○

If "other' please list here:

LIFESTYLE

Rate your level of daily activity and/or exercise:

How many hours per day do you typically spend sitting at a desk, in a car, or on an electronic device?

○ Less than 2 hours ○ 2-5 hours ○ 6 or more hours

Click the right arrow to continue to the next page...

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

CARDIOVASCULAR

	Past	Present
Blood Clots	☐	☐
Cold / Blue Fingers or Toes	☐	☐
Chest Pain	☐	☐
Heart Palpitations	☐	☐
High Blood Pressure	☐	☐
Swelling in Hands / Feet	☐	☐

CONSTITUTIONAL

	Past	Present
Fever	☐	☐
Night Sweats / Chills	☐	☐
Sudden Weight Loss or Gain	☐	☐

HEENT

	Past	Present
Ear Infections	☐	☐
Ringing in Ears	☐	☐
Sinus Congestion	☐	☐
Sore Throat	☐	☐
TMJ / Jaw Pain	☐	☐
Vertigo	☐	☐

IMMUNOLOGIC

	Past	Present
Autoimmune Condition	☐	☐
Food Intolerance / Seasonal Allergies	☐	☐
Eczema / Skin Conditions / Rash	☐	☐

GASTROINTESTINAL

	Past	Present
Acid Reflux / Heartburn	☐	☐
Abdominal Pain / Bloating / Swelling	☐	☐
Constipation / Diarrhea	☐	☐
Nausea / Vomiting	☐	☐

GENITOURINARY

	Past	Present
Bladder & Urination Issues	☐	☐
Fertility Challenges	☐	☐
Ovarian / Uterine Issues	☐	☐
Prostate Issues	☐	☐

MUSCULOSKELETAL

	Past	Present
Arthritis	☐	☐
Joint Stiffness	☐	☐
Muscle Weakness / Cramping	☐	☐

NEUROLOGIC

	Past	Present
Concussions	☐	☐
Headaches / Migraines	☐	☐
Incoordination	☐	☐
Numbness / Tingling Sensations	☐	☐
Paralysis	☐	☐
Seizures	☐	☐
Syncope / Fainting	☐	☐
Tremors	☐	☐

PSYCHOLOGICAL

	Past	Present
Anxiety	☐	☐
Depression	☐	☐
Focus / Attention / Concentration Issues	☐	☐
Sleeping Difficulties	☐	☐

RESPIRATORY

	Past	Present
Asthma	☐	☐
Bronchitis or Pneumonia	☐	☐
Chronic Cough / Colds	☐	☐
Shortness of Breath	☐	☐

ACKNOWLEDGEMENT & CONSENT

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occuring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments, may be a vertebral injury that could lead to a stroke.

Prior to recieving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

e-signature

Signature: Date:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

e-signature

Signature: Date:

Appointment Policy

In our office, we reserve our time to serve you and your family. We understand that life happens and appointments may need to be changed or cancelled for **emergent** reasons. In this event, we request that you give our office a call or message us via SKED within a minimum of **1 hour** prior to your scheduled appointment.

Two "no call, no shows" *in a row* are granted to a practice member in the event of an emergency, but there is no tolerance for chronic "no call, no shows." Following your **third** "no call, no show," our billing department will automatically apply a one-time **$100 NCNS fee** to the credit or debit card on file **per family member** at the end of the business day. Following this fee, the practice member and associated family members' calendars will be deleted from our schedule. If the practice member at this point wishes to continue with their care, we will be happy to rebuild your care visits, but remember, you have already exhausted our cancellation policy, and there will be no more tolerance for missed visits. If you wish to restart care, the cancellation policy will reset, and the **$100 fee will be applied to the first "no call, no show"** of your new calendar.

Being consistent with your care will get you the best results in our office!

In order to discontinue care, we require that you come into the office to go over your account with a team member. This should be scheduled 24 hours in advance to allow ample time to audit your account. At that time, we will either schedule a refund (within 15 days) or take payment for any balance left on the account.

I understand the above cancellation policy as well as the penalty fees that could be applied to my credit or debit card.

Signature: Date:

MEDIA RELEASE FORM

I grant permission to Express Life Chiropractic, hereinafter known as the "Media" to use my image (photographs and/or videos) for use in Media publications including Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, and/or Affiliates.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjuction with them now or in the future, whether that use is known to me or unkown, and I waive the right to royalties or other compensation arising from or related to the use of the image.

I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing, and I fully understand the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgable acceptance of the terms of this release.

Type Signature:

X-RAY AUTHORIZATION

As your helthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request we will provide you with a copy of your x-rays in our files. However, the reproduction of x-rays there will be $15 surcharge for the duplication of x-rays.

Please Note: If clinically necessary, x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Express Life Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

Female Patients: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken at Express Life Chiropractic.

By signing below, you are agreeing to the above terms and conditions.

e-signature

Signature: Date:

INSURANCE POLICIES AND FEE SCHEDULE

Consultation/Assessment (New or Established Practice Member): Includes one or more of the following: practice member history, thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check $50-$100.

Chiropratic Adjustment: The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $30-$60.

X-rays: Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $30 per view. Reproductions of x-rays are $15 per copy.

These prices are not reflective of physical injury or bodily injury cases in relation to car accidents or auto insurance cases.

RELEASE OF AUTHORIZATION/ ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Troy Hayes, D.C. I agree that this authorization will cover all services rendered until i revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been in advance.

A quote of benefits and/or authorization does not guarantee payment or verify eligibilty. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the practice member's insurance at the time of service. Your health/auto insurance company will only pay for services that it deermines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health/auto insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. If my health/auto insurance company denies payment (in whole or in part), I understand that iam personally and fully responsible for payment. I also understand that if my health/auto insurance company does make payment for services, I will be responsible for any co-payment, deductible, out of pocket, or coinsurance that applies.

I understand that I am financially responsible for charges not covered by this assignment.

e-signature

Signature: Date:

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patiet relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate

the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a seperate and distant science, art, and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjsutment process, as defined in the law of this jurisdiction, involved the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify and spinal health problems and chiropractic needs. if during this process, any condition or question outside the scope of chiropractic is identified, you will recieve a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or comete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home, and self-care, etc., is essential to maximize healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

e-signature

Signature: Date: