

Notice of Privacy Practices for Protected Health Information

Great Choice Chiropractic has my permission to discuss my: case history, payment history / schedule, and appointment scheduling with the following individuals:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and understand *Notice of Privacy Practices for Protected Health Information*.

Patient Printed Name

Date

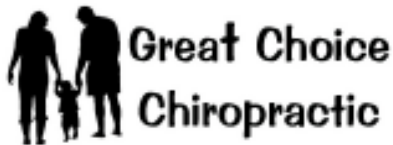
Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature

Description of Personal Representative's Authority to Act for the Patient.



15810 S. 45th St. Suite 160
Ahwatukee, AZ 85048

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity and not dependant on how a person feels.

Subluxation: A misalignment of one or more of the joints in the body which causes alteration of nerve function and / or interference to the transmission of mental impulses, resulting in a lessening of the body's God given ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of gentle forces to facilitate the body's correction of subluxation. Our Chiropractic method of correction is by specific adjustments of the joints using the Activator Methods® Chiropractic Technique and protocol.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a Chiropractic evaluation and treatment, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you to the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our primary method is specific adjusting to correct subluxations.

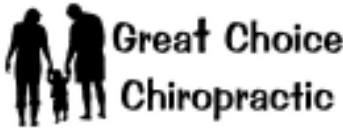
I, _____ have read and fully understand the above statements.
(Print patient's name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care on this basis.

Signature of Responsible Party

Date



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Ahwatukee, AZ 85048

Personal Health History

Today's Date: ____/____/____ Age: ____ Date of Birth: ____/____/____
Name: _____ Female Male Social Security #: ____-____-____
Address: _____ City: _____ State: _____ Zip: _____
Home:(____) _____ Cell:(____) _____ Work:(____) _____
E-mail Address: _____@_____
Height: ____ft ____in Weight: ____lbs Primary care physician: _____
Occupation: _____ Employer: _____
Have you ever been to a Chiropractor? Yes No When? _____
How were you referred to Great Choice Chiropractic? _____

Family Members

Spouse: _____ Age: _____
Child #1: _____ Age: _____
Child #2: _____ Age: _____
Child #3: _____ Age: _____
Child #4: _____ Age: _____

Previous Chiropractic Care?

Yes No Reason: _____
Yes No Reason: _____
Yes No Reason: _____
Yes No Reason: _____
Yes No Reason: _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in Chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

**Chiropractor's
Comments**

Check all that Apply

1. Was Your Birth Traumatic?

- Long Delivery? _____
- Difficult Delivery? _____
- Forceps? _____
- Caesarian? _____
- Breach / cephalic? _____
- Homebirth? _____
- Mother given drugs? _____
- Induced Labor? _____

2. Growth and Development (Did you ever once...)

- Learn to care for your spine? _____
- Fall out of bed? _____
- Bang your head? _____
- Breastfeed? _____
- Childhood sickness? _____
- Have any Accidents? _____
- Have Surgery? _____
- Take Drugs or Medications? _____
- Fall while learning to walk? _____
- Bullied by your siblings? _____
- Chair pulled out when sitting? _____
- Fall down the stairs? _____
- Pulled by your arm? _____
- Child abuse
 - Spanking? _____
 - Pulled ear / chin _____
 - Other _____
- Experience other traumas? _____

Name: _____

3. Current Health Habits (Did / do you...)

- Smoke? _____
- Drink alcohol? _____
- Diet (do you eat healthy foods?) _____
- Have you been in accidents? _____
- Have you had surgery and organs replaced/removed? _____

- Drugs? (Prescriptive or Non-Prescriptive)
- Have Teeth Problems?
- Have Eye Problems?
- Have Hearing Problems?
- Exercise regularly?
- Have sleeping problems? (Nightmares)?
- Have occupational stress?
- Have physical stress?
- Have mental stress?
- Have hobbies/sports injuries?

Sleeping posture - - side stomach back

Current Health Condition

Present Complaint (Reason for today's visit): _____

PERSONAL & FAMILY HISTORY

Number of Brothers and Sisters: _____ F = Family S = Self **Circle or check all that apply**

<ul style="list-style-type: none"> F S - AIDS / HIV F S - Allergies F S - Alzheimer's disease F S - Anemia F S - Anxiety F S - Arthritis F S - Auto accident(s) F S - Other accidents / falls F S - Bed wetting F S - Blood in urine / stool F S - Blurred / Double vision F S - Breast soreness F S - Cancer F S - Change in bowel / urinary habits F S - Chest pain F S - Cold hands / feet F S - Constipation F S - Convulsions / Epilepsy F S - Depression F S - Diabetes F S - Diarrhea F S - Difficulty concentrating F S - Dizziness F S - Eating disorders F S - Extreme fatigue F S - Eyes sensitive to light F S - Eye strain / loss of focus F S - Fainting F S - Frequent colds / flu F S - Frequent ear infections F S - Hearing loss F S - Heart disease F S - Hemorrhoids F S - Hepatitis F S - High / Low blood pressure F S - Irritability 	<ul style="list-style-type: none"> F S - Loss of memory F S - Loss of taste F S - Loss of smell F S - Mental dullness F S - Mood swings F S - Nausea / vomiting F S - Nervousness F S - Neuritis F S - Nose bleeds F S - Osteoporosis F S - Palpitation F S - Parkinson's disease F S - Ringing / Buzzing in ear(s) F S - Shortness of breath F S - Sleeping difficulty F S - Stress F S - Stroke F S - Tension F S - Tremors F S - Ulcers F S - Varicose veins F S - Visual disturbances F S - Weight gain or loss <p>Trouble with:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Balance / Equilibrium <input type="checkbox"/> Sinus <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Gall bladder <input type="checkbox"/> Kidney <input type="checkbox"/> Digestion <input type="checkbox"/> Menstruation <input type="checkbox"/> Impotence <input type="checkbox"/> Prostate 	<p>Difficulty with excessive:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Walking <input type="checkbox"/> Riding Bending: <input type="checkbox"/>Rt <input type="checkbox"/>Lt <input type="checkbox"/>Forward <input type="checkbox"/>Back Lifting: <input type="checkbox"/>Light <input type="checkbox"/>Heavy <input type="checkbox"/>Repetitive <input type="checkbox"/> Other: _____ <p>Numbness / tingling in:</p> <ul style="list-style-type: none"> Arms: <input type="checkbox"/>Right <input type="checkbox"/>Left Hands: <input type="checkbox"/>Right <input type="checkbox"/>Left Fingers: <input type="checkbox"/>Right <input type="checkbox"/>Left Buttocks: <input type="checkbox"/>Right <input type="checkbox"/>Left Legs: <input type="checkbox"/>Right <input type="checkbox"/>Left Feet: <input type="checkbox"/>Right <input type="checkbox"/>Left Toes: <input type="checkbox"/>Right <input type="checkbox"/>Left <p>Pain / stiffness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Behind eyes <input type="checkbox"/> Headaches Jaw-clicking (TMJ): <input type="checkbox"/>Right <input type="checkbox"/>Left <input type="checkbox"/> Neck Shoulder: <input type="checkbox"/>Right <input type="checkbox"/>Left Arm: <input type="checkbox"/>Right <input type="checkbox"/>Left Hand / Wrist: <input type="checkbox"/>Right <input type="checkbox"/>Left Fingers: <input type="checkbox"/>Right <input type="checkbox"/>Left <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back (between shoulder blades) <input type="checkbox"/> Lower back <input type="checkbox"/> When coughing or sneezing Hip: <input type="checkbox"/>Right <input type="checkbox"/>Left Knee: <input type="checkbox"/>Right <input type="checkbox"/>Left Foot / Ankle: <input type="checkbox"/>Right <input type="checkbox"/>Left Toes: <input type="checkbox"/>Right <input type="checkbox"/>Left
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Ahwatukee, AZ 85048
(480) 704-6600

Informed Consent Form

I, _____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Greg Hauser, D.C., F.I.C.P.A. and **Great Choice Chiropractic.**

I have had an opportunity to discuss with the doctor and the clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that neither the practice of chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results had been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

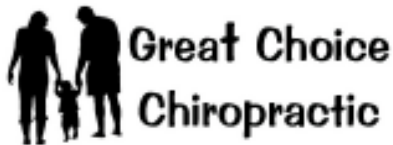
I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, stroke, dislocations, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or have had explained to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient Signature: _____

Date: _____

Patient name (print): _____



Office Policies & Procedures

Please Read and Initial

 1. Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

 2. Appointments: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule it within 24 hours so you stay on target for wellness. It is your responsibility to get here. We will do all we can to accommodate you.

 3. Daily Visit Procedure: We value your time and the time of other patients. Each time you arrive for your adjustment, you will be assigned a room. Turn off all electronic devices (i.e. cell phones, pagers, hand-held games, etc.) as these are a distraction. Please stay in the room and the doctor will be with you soon. Once the doctor learns your spine, your adjustments will take only a few minutes and be very focused. Please help keep things moving for yourself and for others by being ready for your adjustment when the doctor enters the room.

 4. Dynamic Examinations: During your Initial Intensive Care you will receive several Dynamic Examinations to monitor your level of spinal correction. On this visit you will fill out an Update Form and be taken to the Exam Room. All the findings from your initial visit will be retested. Plan on spending 10-15 extra minutes for these appointments. There is an additional fee for this visit unless you are on a payment plan that is all-inclusive. Immediately following your Dynamic Examination, the doctor will sit down with you to discuss your results. At the end of your Corrective Adjustment Plan you will receive recommendations for a Wellness Adjustment Plan to help you stay as healthy as possible.

 5. Orientation: This is the single most important visit we provide because it is where you'll learn how to get the best results from Chiropractic. It is our policy that you attend one Orientation within the first 2 weeks of care. We recommend that you bring your spouse, a family member or friend with you so you create a support group who understand what you're going through and help keep you focused on your desired results. Also, if you know anyone else with a health problem, or is committed to a wellness lifestyle, our Orientation would be a great way to introduce him or her to our office and Chiropractic without any obligation or financial commitment. The fee for your orientation is included in your exam fees. Doctor's Reports are held on Monday evenings at 6:15.

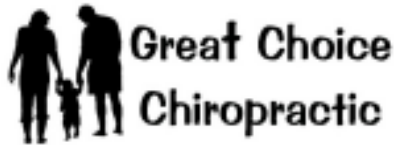
 6. Results: We are very results oriented, however many factors that we have no control over affect how quickly you respond to your care. These include your age, occupation, how long you have had your subluxations, and how many subluxations are present in your body. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current condition of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

Signature: _____

Date: _____

Congratulations on choosing Chiropractic.

Follow through with your family, and enjoy the health benefits that come with a Chiropractic Lifestyle.



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Service Fee Schedule and Financial Policy

<u>Service</u>	<u>Regular Fee</u>	<u>Time of Service Discounted Fee</u>
Initial Consultation	No charge	No charge
Initial Exam with Computer Scans	\$110-225	\$60-175
X-Rays (per view)	\$30- 55 per view	\$30-55 per series
Reporting of Doctor's Findings	\$50-80	\$50
Periodic Dynamic Exam	\$60	\$40
Adjustment	\$55-95	\$55
Therapeutic / Rehabilitative Services	\$30-40 per service	\$30-40 per visit
Individual Wellness Adjustment Plans	Not applicable	\$50 - \$200 per month
Family Wellness Adjustments Plans	Not applicable	\$100+ per month

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best Chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your Chiropractic report. Please choose one of the following fee options:

_____ Regular Fees: If you have health insurance that covers Chiropractic and choose to use it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Any and all insurance payments and accompanying paperwork will be brought to our office for proper processing of claims and distribution of funds.

_____ Time of Service Discounted Fees: If you do not have health insurance, choose not to use your health insurance, or are participating in a Wellness Adjustment Plan, you will be eligible for the Time of Service Discounted Fees above. You may request a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for Chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the discounted fees again.

*Please note that all "health insurance" coverage (including Medicare) is NOT allowed to be used for Wellness Adjustment Plans (see your insurance contract for details).

Regardless of the financial arrangements or method of payment, it is **Great Choice Chiropractic's policy to **collect \$79 on the first visit**, which will be applied toward the balance of the first visit charges.

Patient signature

Date