cornerstone
WELLNESS CENTER

Name_____ How would you like to be addressed? _____

Mobile#_____-_____ **Email Address**: _____

Address_____**City**_____**ST**_____**Zip**_____

Gender: M or **F DOB**__/__/____**Age**___ **SS#**_____-_____-_____**Marital Status**: _____

Employer: _____ **Occupation:** _____

Physicians Name: _____ **Phone#**_____

Emergency Contact_____ **Phone#**_____

Who can we thank for referring you? _____

Have you ever had Chiropractic Care? Y or N If so, was it a positive experience? Y or N

Medical History:

Please check if you have or ever had:

[ ] Arthritis
[ ] Osteoporosis/Osteopenia
[ ] Heart problems
[ ] Lung problems
[ ] Diabetes
[ ] Head injury
[ ] Muscular Dystrophy
[ ] Seizures/epilepsy
[ ] Thyroid problems
[ ] Cancer _____
[ ] Hepatitis
[ ] Skin diseases
[ ] Pacemaker
[ ] Hernia
[ ] Concussion
[ ] Broken Bones
[ ] High Blood Pressure
[ ] Stroke
[ ] Multiple Sclerosis
[ ] Parkinson's disease
[ ] Allergies
[ ] Tuberculosis
[ ] Depression
[ ] Fibromyalgia
[ ] Migraines
[ ] Asthma
[ ] Anemia
[ ] Are you currently pregnant? _____
[ ] Numbness Weakness or Tingling

Other Illnesses/ Diseases:

_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____

Current Supplements:

_____
_____
_____
_____

Surgeries (include year):

_____
_____
_____
_____

PATIENT NAME: _____

1. Chief Complaint : _____
When did it start? _____ Gradual / Sudden
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

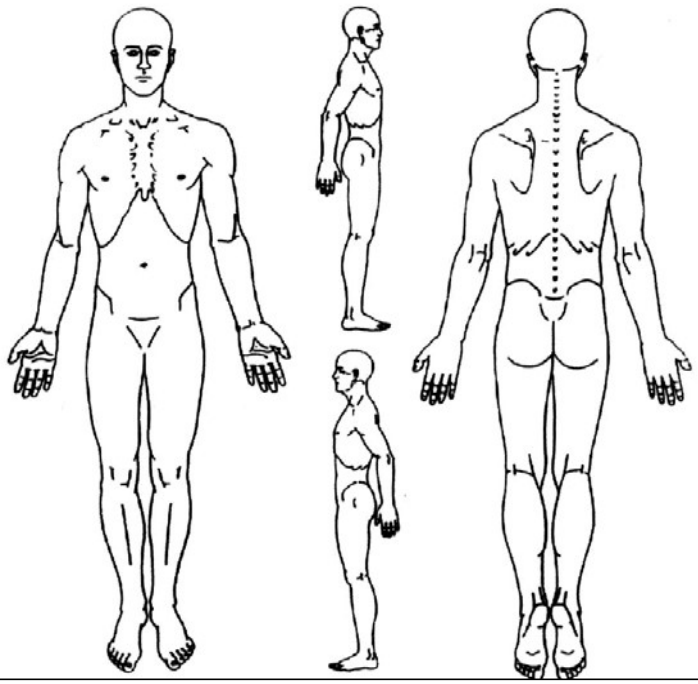
2. Chief Complaint : _____
When did it start? _____ Gradual / Sudden
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

3. Chief Complaint : _____
When did it start? _____ Gradual / Sudden
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

What job activities are you unable to do? _____
When do you feel it most? ☐ AM ☐ PM When present, how long does the complaint last? _____Mins _____Hrs
What makes it feel better? _____ What makes it feel worse? _____

Using the letters below, please show where you are experiencing all of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Walking	Y	N
Computer work	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

1. Have you ever had tests for your present condition? ☐ MRI ☐ Xray ☐ CT ☐ Other _____
2. Do you have a pacemaker? ☐ Yes ☐ No Do you have any artificial joints or metal in other regions?_____
3. Have you ever lost work due to your condition(s)? ☐ Yes ☐ No If Yes, dates? _____
4. Are you pregnant? ☐ Yes ☐ No Number of pregnancies? _____ Number of miscarriages? _____
5. What was the first day of your last menstrual cycle? _____

If you have not been in the office in over 30 days a re-examination may be necessary and an additional charge may occur.

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High
0 1 2 3 4 5 6 7 8 9 10

What is YOUR goal for treatment? _____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge:

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____

STAFF USE ONLY **Height:** _____inch **Weight:** _____ pounds **BP**_____ /_____ P _____

Office Policy, Procedures & Disclosures

Cancellation Policy:

There is a $35 charge for missed appointments without a 24-hour advance notice for any appointment with the Chiropractor, Physical Therapist, Acupuncturist and/or the Massage Therapist. For those patients who have purchased a massage package, one massage will be used from the package if the appointment is not cancelled 24 hours before the scheduled massage.

Consent to care

As a patient with Cornerstone Wellness Center, you have the right to know the types of treatment we could possibly use and any complications/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however, unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. Patients are responsible for informing doctors about any conditions, diseases, illnesses, etc. Patients agree to settle any claim or dispute against or with our clinic or personnel, when related to the prescribed care or otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. Cornerstone Wellness Center may refer you out to other ancillary services that Cornerstone Wellness Center may have ownership to. Patients hereby allow treatment to be rendered to themselves by all Cornerstone Wellness Center, physicians or staff.

Financial Policy

The patient is ultimately responsible for full payment of their treatment and care whether or not paid by insurance. Your insurance Policy is a contract between you and your insurance. As a courtesy, we check your insurance for benefits. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payments of co-pays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients authorize the release of healthcare information and records to all insurance companies. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit and debit cards at our office. Any prepaid packages are refundable if not used within 90 days of payment. After 90 days, the unused portion will revert to a credit which must be used within 2 years of original payment. Any credits not used within the two years will be forfeited. Any insurance checks sent directly to you or the insurance policy holder for services rendered with Cornerstone Wellness Center must be brought into our clinic.

Collections

If a patient's account is not paid in full within 90 days, it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are current. Delinquent accounts will be turned over to a licensed collection agency; there will be a collection fee equal to 30% of our outstanding balance at the time the account is placed with the collection agency.

Miscellaneous:

There is a $35 charge for forms completion by our Providers, including but not limited to disability and FMLA forms.

****

I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Disclosure Form:
Please sign/date below:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____Witness:_____

Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving **Cornerstone Wellness Center authorization** to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- I may be contacted by home, work, or cellphone.
- Messages may be left on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- Also I may be contacted by postal mail or e-mail to send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders.
- With my permission, my name and or photograph may be used for office events, bulletin boards, newsletters or patient testimonials.

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the privacy Official of **Cornerstone Wellness Center.** The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Officials.

This AUTHORIZATION is requested by **Cornerstone Wellness Center** for its own use/ disclosure of protected health information. (Minimum necessary standards apply.) You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION **Cornerstone Wellness Center** will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

Personal representatives (family members, attorneys, etc. I hereby authorize **Cornerstone Wellness Center** and its employee's to discuss, send and/ or receive medical information to/with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

We like to co-manage your case with your Primary Care Physician; do you authorize us to send notes or records to them? Yes No

If yes, please provide us the following information: Primary Care Doctor_____Office Phone#_____

My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of **Cornerstone Wellness Center** Notice of Privacy Practices.

Patient Name (print):_____ Patient Representative (print):_____

Patient Signature:_____ Patient Representative Signature:_____

Date:_____/_____/_____