FIX24 Joint Biomechanics
Scottsdale 101 - 7000 E. Mayo Blvd. Suite 1058 Phoenix, AZ 85054
p. 480.419.1500 f. 480.419.1605

CASE HISTORY

Name_____ Sex M F Date _____

Address _____ City/State _____

H. Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ Age_____

Occupation_____ Email_____

Referred by:_____ Is this related to a work/personal injury? Yes No

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason:_____

Secondary reason:_____

Other factors contributing to the primary and secondary reasons:_____

2. Chief complaint: _____

Location of complaint:_____

Complaint began when and how?_____

Circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other

Does this complaint radiate/travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where?_____

Grade intensity/severity (no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain/complaint)

How frequent is complain present, how long does it last? _____

Does anything aggravate the complaint?_____

Does anything make the complaint better?_____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:_____

_____

4. Past health history:_____

A**. Previous illnesses you've had in your life:**_____

B. Previous injury or trauma:_____

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Have you ever broken any bones? Which? _____

C. Allergies: _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females/Pregnancies and outcomes:

Pregnancies	Date of Delivery
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period?_____

5. Family/Health History: Associated health problems of relatives:_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

A. Job description: _____

B. Work schedule:_____

C. Recreational activities:_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco, and drug use, diet):

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient/Parent/Guardian Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

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Office Financial Policy Addendum

FIX24 is solely a cash practice. We gladly accept cash, credit card, and checks for our services. We also provide discounted payment options to help minimize the financial burden associated with your health recovery. We also offer 'Care Credit' for easy financing of your health recovery costs.

FIX24 is a 'non-participating' provider for Medicare patients. Medicare coverage and non-coverage will be explained to you prior to treatment.

FIX24 is not contracted with any insurance company, therefore FIX24 and your treatment program are not governed by third party insurance companies. In order to keep the cost of your care efficient, we do not have an insurance billing department. Our focus is to get you better with a fair price and as quickly as possible.

FIX24 does not provide patients with insurance coded super bills. We do not submit claims or any service provided by FIX24 to any insurance company for approval or reimbursement purposes.

Payment is required prior to services rendered.

I have read and fully understand the above mentioned FIX24 Financial Policy.

Signature_____ Date_____

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Authorization to Perform X-Rays

The physicians at FIX24 have informed me that diagnostic x-rays are advisable to complete a thorough analysis of my case in combination with physical exams for my present musculoskeletal condition. I authorize the chiropractic physicians at FIX24 to perform the necessary radiographic examination to diagnose and administer treatment they deem appropriate to treat my current problem.

Patient Signature:_____ Date:_____

FEMALES ONLY

To the best of my knowledge, I am NOT Pregnant at the physicians at FIX24 have my permission to x-ray me for the purpose of diagnosis and treatment of my condition. I have been advised that x-ray can be hazardous to an unborn child.

Patient Signature:_____ Date:_____

FOR MINORS ONLY - CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

Print name: _____ Signature: _____ Date:_____

Informed Consent for FIX24 Wellness Studio

I hereby request and consent to the performance of chiropractic procedure, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as a backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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, and is in my best interest.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other that chiropractic procedures. These treatment options include, but not limited to, self-administered, over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient (Print):_____ Signature:_____ Date:_____
Doctor:_____ Date:_____

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APPOINTMENT REMINDERS and HEALTHCARE INFORMATION AUTHORIZATION

FIX24 LLC and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your healthcare information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.
Information that we use or disclose based on the authorization you are giving us may be subject to disclosure by anyone who has access to the remainder or other information and may no longer be protected by the federal privacy rules.
You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last receive service from us. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Signature_____ Date_____

Who is your Primary Care Physician (PCP) so that we may collaborate and provide update on your care? _____

I authorize this office to discuss my medical care or treatment with the following person(s):

Name:_____ Relationship:_____ PT Initials:_____

Name:_____ Relationship:_____ PT Initials:_____

Patient Signature:_____ Date:_____

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_____

Last Name First Name MI

Patient record#:

_____

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Date of Birth: ____/_____/_____

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for _____ County/District Health Department; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____
Signature of patient or parent/legal guardian/legally responsible person Date

_____
Description of relationship to patient

FOR OFFICE USE ONLY

Complete all applicable parts

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

□ Patient/personal representative refused to sign form

□ Other _____

□ Form mailed/sent to patient/personal representative on _____.

_____ _____
Signature of staff member Date

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Appointment Cancellation Policy

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an appointment cancellation policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it's missed, that time cannot be used to treat another patient.

Therefore, our policy is as follows:

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment, and you will be charged the entirety of the appointment fee and no future appointments can be scheduled without the payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have

We thank you so much for being part of our family of patients and we value all of you!

I have read and understand the appointment cancellation policy of the practice and I agree to its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I, _____ (print name), acknowledge FIX24's appointment cancellation policy.

Signature_____Date_____