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):
_____
_____
_____
_____

Where are your symptoms located?

1. Symptom location_____ when did it start? _____ Gradual/Sudden
   1 2 3 4 5 6 7 8 9 10 pain at its worst (1-10)? _____what percent of the day do you feel it? ____%
   Mild Severe

How did this injury happen? _____

2. Symptom location_____ when did it start? _____ Gradual/Sudden
   1 2 3 4 5 6 7 8 9 10 pain at its worst (1-10)? _____what percent of the day do you feel it? ____%
   Mild Severe

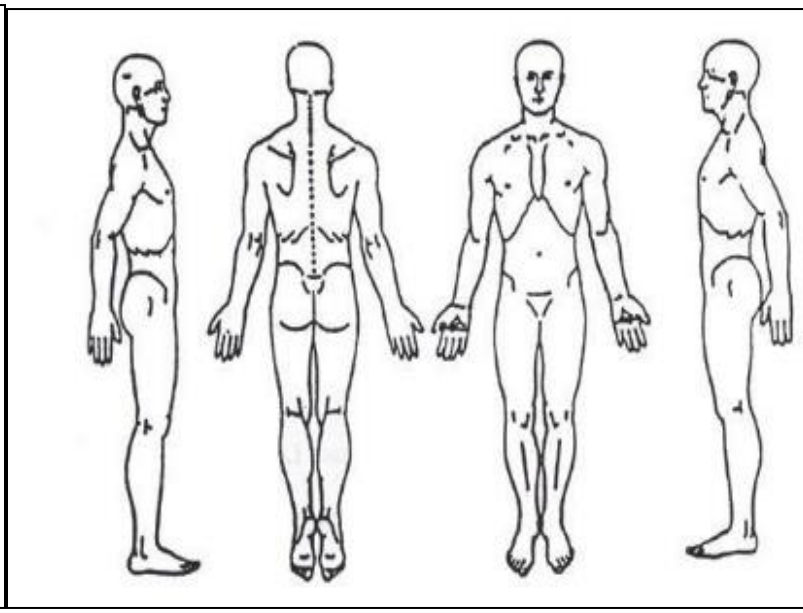
How did this injury happen? _____

3. Symptom location_____ when did it start? _____ Gradual/Sudden
   1 2 3 4 5 6 7 8 9 10 pain at its worst (1-10)? _____what percent of the day do you feel it? ____%
   Mild Severe

How did this injury happen? _____

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



1. Have you ever had tests for your present condition? MRI X-Ray 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? _____
6. What is YOUR goal for treatment? _____

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

_____

7. What makes your pain better? _____

8. What makes your pain worse? _____

Patient Name (please print):_____

Patient Signature: _____ Date: _____ Dr. Initials_____

Do you currently have pain and/or difficulty preforming 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

Office Policy, Procedures & Disclosures

Medical/Chiropractic Department:

I understand that there is a $35 charge for missed appointments without a 24 hour advance notice for any appointment with the Chiropractic Physician, Physical Therapist, Acupuncturist and or the Massage Therapist.

I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we check your insurance or superbill. 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 payment of copays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. 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. Some insurance companies send you the provider's checks; you as the patient are responsible to bring those checks to our office with the EOB's as soon as you receive them.

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. I am responsible for informing my doctors about any conditions, diseases, illness, etc. I agree to settle any claim or dispute against or with our clinic or personal, 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. I hereby allow treatment to be rendered to myself by all **Cornerstone Wellness Center Physicians staff.**

Financial Policy

I agree that any insurance checks sent directly to me or insurance policy holder for services rendered with Cornerstone Wellness Center will be brought into our clinic.

I the undersigned, assign directly to Cornerstone Physical Medicine LLC (dba Cornerstone Wellness Center) all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of healthcare information and records to all insurance companies and to other treating providers whom I am seeking care from.

****

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:_____/_____/_____