

Dr. Tom Bench
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 Idaho Falls, ID 83404
 208-552-9600
 208-524-6402 Fax
www.evochiropractic.com

Patient Information & History

Date: _____

Please present insurance card(s) so we can put a copy in your file.

PATIENT INFORMATION

Name: _____

(First)

(M.I.)

(Last)

(Name called by)

Home Phone _____ Cell _____ Work _____ Ext. _____

Email _____ Best way to reach you: Home Cell Work Email

*If you do not want our monthly newsletter/promotions please check here to opt out.

Social Security # _____ / _____ / _____ Birthday: _____ Age: _____ Male Female

Address: _____ City/State: _____ Zip: _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____ Home Phone _____ Cell _____

Occupation: _____ Employer: _____

Single Married Divorced Widowed Separated Spouse's Name: _____

How did you hear about us? _____

Parents Name (if a minor): _____

HEALTH HISTORY

Date of Last: Spinal X-Ray _____ MRI _____ CT-Scan _____ Other _____

List any Medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant? Yes No Due Date: _____ Beginning of last menstrual cycle _____

PATIENT CONDITION

What is your major symptom/problem?

When did your symptoms begin? _____ Have you had this problem before? Yes No

Is your condition getting progressively worse? Yes No Is this problem: 100% 75% 50% 25% of the day

How does it feel? Burning Sharp Shooting Dull Aching Stiff Tingling Throbbing Swelling
Other _____

Circle below the severity of your pain on a scale of 0 to 10: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

What makes your condition better? _____ Worse? _____

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

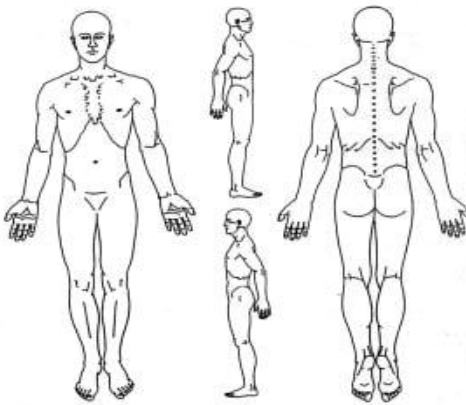
What other treatments have you had for this condition?

- Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Other Symptoms other than major condition: _____



Check any of the following conditions you have had: Place a star by anything current.

- | | | |
|--------------------|----------------------|----------------------|
| AIDS/HIV | Ear Ringing | Neck pain |
| Allergies | Epilepsy | Osteoporosis |
| Anxiety/Depression | Headaches | Poor circulation |
| Arm/shoulder pain | Headaches - Migraine | Prostate problems |
| Arthritis | Heart Disease | Rheumatoid Arthritis |
| Asthma | Hemorrhoids | Sciatica |
| Bladder problems | Herniated disk | Shingles |
| Cancer | High Blood Pressure | Sinus Infection |
| Chronic fatigue | Insomnia | Stroke |
| Deafness | Irregular cycle | Thyroid problems |
| Diabetes | Kidney Problems | TMJ |
| Digestion problems | Leg pain | Venereal Disease |
| Earache | Low back pain | Vertigo/Dizziness |

Please mark your symptoms as described below :

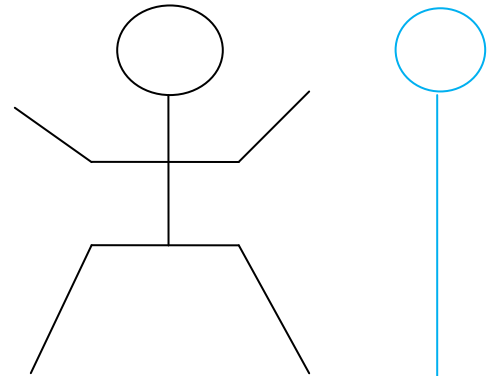
X- pain O- ache //- pins and needles ^^- numbness

For Office Use Only:

VITALS

Temp:
Pulse:
BP:
Resp:
Height:
Weight:

CROM:
TROM:
LROM:



STRESSORS

- Smoking _____ Packs/Day _____
- Alcohol _____ Drinks/Week _____
- Coffee/Caffeine Drinks _____ Cups/Day _____
- High Stress Level _____ Reason _____

EXERCISE

- None
- Moderate
- Daily
- Heavy

Have you had any:	Description	Date
Automobile Accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls/Head Injuries	_____	_____

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Evolution Chiropractic / Thomas Bench, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____ Signature	_____ Date	_____ Parent (if patient is a minor)
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Financial Agreement

Thank you for choosing us as your health care provider. We are committed to giving you the best care available. We hope the following will answer any questions you may have about our insurance and billing procedures and policies in relation to your appointment and procedures.

Insurance: Your insurance policy is a contract between you and your insurance company. We cannot guarantee to you that your insurance will pay all, or any part, of your claim. If your company denies, or only pays a portion of your claim, you are personally responsible for your total outstanding account balance(s).

Regarding insurance plans where we are a participating provider, all co-pays, deductibles and co-insurance are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred. In summary, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out of network benefit
- Self pay patients must pay in full at time of service.

X _____	Date: _____
Signature of Patient or Responsible Party	

Witness: _____	Date: _____
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Notice of Privacy Practices

Keeping your medical records confidential – What you need to know about Evolution Chiropractic: Evolution Chiropractic is committed to providing you with high quality care and forming a relationship with you that is built on trust. That means respecting your privacy and confidentiality of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice Evolution Chiropractic policies and procedures that allow access to your personal medical information only for legitimate reasons.

Your medical record - As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential – You, or anyone to whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Evolution Chiropractic.

How do we assure your privacy? – Evolution Chiropractic has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside of this facility. The policies conform to state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from his or her job.

We ask your permission – We do not allow others outside of Evolution Chiropractic access to any information unless we have the appropriate authorization to do so. We will respect your authorization to release information on your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

- *Confidential details of: Psychotherapy (treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist.
- *Other professional services of a licensed psychologist * Social Work Counseling/therapy * Domestic Violence Victims Counseling
- * Sexual Assault Counseling * HIV Test Results * Records pertaining to Sexually transmitted diseases * Alcohol and drug abuse records -

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of the abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Evolution Chiropractic follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Evolution Chiropractic without your written approval. In all research conducted within Evolution Chiropractic, concern for your privacy and well-being is our first priority. If you have any questions about the privacy of your medical records, please speak with us. We will be happy to help you.

Patient Acknowledgment of Privacy Practices

Patient Name _____

DOB _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of the patient). _____



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Printed name of Patient

Date of Birth

Signature of Patient

Date

CONSENT TO TREAT A MINOR

I, _____(Parent or legal guardian) do hereby consent to have Dr. Tom Bench at Evolution Chiropractic, render care to my son/daughter/etc. _____ who is _____ years of age. Date of birth of child _____.

Signature of Parent or Legal Guardian _____ Relationship _____

Witness: _____ Date _____