**Patient Name: _____Date: _____ Email: _____**

**SSN#/SIN: _____-____-____ DOB: _____ Cell Phone: _____ Home Phone: _____**

**Circle One: Minor Single Married Divorced Widowed Separated Male: _____ Female: _____**

**Patient Address: _____ City: _____ State: _____ Zip: _____**

**Employer Name (if applicable): _____**

**Spouse/Guardian Name: _____ Spouse's Employer: _____**

**Emergency Contact: _____ Relationship: _____ Phone: _____**

**Name of person responsible for this account: _____ Relationship to Patient: _____**

**Primary Care Physician: _____ Clinic: _____ Phone: _____**

**How did you learn about us? _____ Who referred you? _____**

## ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Array Medical Center, Surprise** (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or services provided after my insurance company(s) have determined my benefits. I hereby authorize payment of and assign my rights to any medications that have been or will be rendered or provided. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that are needed to file and process insurance medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA-governed plan/insurance contract, PPACA-governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or an administrator. I hereby also declare that the Healthcare provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA and that Healthcare Provider can pursue any and all rights that I/we may have under state and /or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by the Healthcare Provider. A photocopy or scan of this document is to be considered valid and as enforceable as the original.

_____ _____ _____

**Patient Signature** **Print Name** **Date**

**Health History:**

**Chief Complaint: _____**

**History of Present Illness:**

**Location: _____Quality: _____ Severity: _____**
**(Where is the pain/problem) (Example: normal vs abnormal color ect.) (On a scale of 1-10)**

**Duration: _____ Timing: _____ Context: _____**
**(How long have you had the pain/problem) (Does the pain/problem occur at a specific time?) (When did it start)**

**Signs/Symptoms: _____ Modifying Factors: _____**
**(What associated problems have you been experiencing?) (What makes the pain/problem worse or better?)**

**Have you had previous Tx for this condition: _____**
**(What providers have you seen?)**
**Outcome: _____**

**Anything else tried to handle pain/problem: _____**
**(What other Tx options have you tried?)**
**Outcome: _____**

**Medications: (include non-prescription, vitamins): _____**
**_____**
**_____**
**_____**
**_____**

**Allergies: _____**
**_____**

**OFFICE USE ONLY:**

Height: _____

Weight: _____

Blood Pressure: _____

Oxygen: _____

Pulse: _____

**NOTES:**

**Past Medical History:**

**Please list any diseases, illnesses, diagnosed disorders, and implanted devices (such as Cancer, Heart Disease, Hypothyroidism, Autoimmune disease, Parkinson's disease, Rheumatoid Arthritis, Pacemaker, etc.)**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Are you Diabetic? _____ Type: _____ Last A1C: _____**

**Medications currently taking: _____**

**_____**

| **Previous Hospitalizations/Surgeries/Accidents** | **When?** | **Hospital, City, State** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Patient Social History:**

**Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____**
**Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____**
**Use of Drugs Never: _____ Rarely: _____ Moderate: _____ Daily: _____**
**Excessive Exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Noises: _____**

**Family Medical History:**

| | **Age** | **Diseases** | **if Deceased, cause of Death** |
|---|---|---|---|
| **Father** | _____ | _____ | _____ |
| **Mother** | _____ | _____ | _____ |
| **Siblings** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

# NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

**Name: _____ Date: _____**

**For any YES answer, please explain in the comment section.**

**Do you suffer from neck pain with pain in your shoulders, arms, or hands? YES NO**
**Comment: _____**

**Do you have weakness, numbness or burning in your shoulders, arms, and hands? YES NO**
**Comment: _____**

**Do your hands or arms fall asleep regularly? YES NO**
**Comment: _____**

**Do you have reduced feeling (sensation) or swelling in your hands or arms? YES NO**
**Comment: _____**

**Do you suffer from a loss of handgrip strength? YES NO**
**Comment: _____**

**Do you suffer from back pain with pain in your buttocks, legs, or feet? YES NO**
**Comment: _____**

**Do you have weakness, numbness or burning in your buttocks, legs, or feet? YES NO**
**Comment: _____**

**Do your legs or feet fall asleep regularly? YES NO**
**Comment: _____**

**Do you have reduced feeling (sensation) or swelling in your legs or feet? YES NO**
**Comment: _____**

**Do you suffer from cold hands or feet? YES NO**
**Comment: _____**

**Do you suffer headaches, dizziness, or memory loss? YES NO**
**Comment: _____**

**Do you have difficulty maintaining your balance? YES NO**
**Comment: _____**

**Do you suffer from vertigo or blurred vision? YES NO**
**Comment: _____**

**Do you suffer from ringing in your ears? YES NO**
**Comment: _____**

**Do you have bladder or bowel control problems on a regular basis? YES NO**
**Comment: _____**

# Rules of the Healing Game

**We take great pride and enormous responsibility with the care you have entrusted us to provide you. With our pledge to you we have outlined all we will do for you here in the office. In order to achieve the most optimum results for yourself it is important for you to understand the rules of the healing game. In order to play we need you to be an active member of our team!**

**Here are the rules to the healing game for you, our teammate:**

1) **Stay positive!! We are working on slowing and reversing years of degeneration. This is a process that takes time. Most patients take until the last quarter of treatment to see a reduction in symptoms. So do not be discouraged if you see others noticing changes at earlier times than you. Our bodies all respond to treatment at different rates; therefore, each patient is treated as an individual.**

2) **Hold yourself accountable for your health! Perform the exercises and take the supplements as recommended. We will monitor this with you at each visit and help you to achieve your goals.**

3) **Show up! Be consistent with your appointments. Consistency is key for success and getting you to feel better.**

4) **Be on time! We respect your time and work very hard to ensure you do not have long wait times. Please be courteous to the other patients and arrive at your scheduled appointment time.**

5) **Celebrate improvements. Write down your improvements and changes you notice in your symptoms, daily activities, and overall health. It is the small improvements that build up as you go along.**

6) **ASK QUESTIONS or ASK FOR HELP!!! Just like our teachers used to say in school, "There's no such thing as a stupid question," We are here to answer any question, help you through tough times and keep you informed every step of the way. It is our pleasure to help you. Speak up if you need our help.**

7) **Challenge yourself to do more than you think is possible. This treatment is a process and takes effort. Sometimes it may challenge you in ways you didn't see coming. If that happens, know you are strong for tackling your Neuropathy head on and you can do this. We are on your team and here to support you.**

8) **Support others around you to improve their health. Each patient has a different journey, but support and encouragement from other patients help everyone succeed. No negativity to other patients.**

9) **Lastly, HAVE FUN!!! Make the most of your visit when you come in for treatment…..read, relax, make new friends and enjoy your time.**

# CONSENT TO TREAT

**I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other medical procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic and/or office listed below.**

**I understand and am informed that, as in the practice of medicine, there are some risks to treatment and diagnostic services including but not limited to:**

- **Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.**

- **Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.**

- **Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.**

**I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor has additionally explained the risks associated with my refusal of treatment and I understand that the results are not guaranteed.**

**I have read, or have had it 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**Patient/Guardian Signature: _____ Date: _____**

**Name printed: _____**

**Witness Signature: _____ Date_____**

# CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

**I understand that as part of my healthcare, Array Medical Center Surprise maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:**

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source of information for applying my diagnosis and procedural information to my bill**
- **A means by which a third-party payer can verify that services billed were actually provided.**
- **And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

**I understand and have been provided with a Notice of Privacy Practices for review that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the request restrictions as to how my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used to disclose to carry our treatment, payment, or health operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.**

**_____ I request the following restrictions to the use or disclosure of my health information:**

**_____I have read, have no additional restrictions, and I would like to be provided with a hard copy of the Notice of Privacy Practices.**

**_____I have read, the Notice of Privacy Practices, have no additional restrictions, and I do NOT require a printed hard copy.**

**Date Notice Effective_____ Accepted_____ Denied_____**

**Signature of Patient/Legal Representative_____**

**Witness_____ Date_____**

# OFFICE POLICIES

**APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. We apologize in advance for any unforeseeable delay you may experience. If you are more than 15 minutes late for your appointment you will be asked to reschedule. Cancellations must be made 24 hours prior to your appointment.**

## *** WE CHARGE $45.00 FOR MISSED APPOINTMENTS***

**Social Security Numbers: We handle patient social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use SSN for insurance and billing purposes. This is the required information that we ask for from each of our patients.**

**MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave your children unattended in the waiting area. A staff member will always be available to sit with your child during your treatment if needed.**

**CONDUCT: The golden rule, "Treat others as you wish to be treated" will always be followed in our office. If you as a patient cannot be kind to the staff or other patrons, we can ask kindly for the appointment to be rescheduled. If you see any misconduct inform a staff member who can assist you.**

**PAYMENT: payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master card, Discover, American Express, HSA and HRA.**
**In the event your account gets turned over to collections, you will be responsible for the collections fee up to 25% on top of the balance that is owed to Array Medical Center.**

**INSURANCE: we participate with several major insurance carriers. Our office policies concerning the deductible and HAS/HRA plans are as follows: Patients are responsible for their coinsurance, deductibles, and co-pays in full. Payments are due at the time of service and are based on the patient's insurance company's contracted rates. I consent to Array Medical Center billing my insurance company for my treatment.**

**DIVORCEMENT: We reserve the right to refuse service to anyone at any time for any reason. If our clinic makes the decision to divorce you as a patient, you will receive a written notice. In addition, you will be given 30 days to find your new primary care provider before we completely refuse to schedule you.**

**ACKNOWLEDGMENT: I have read, understand, and agree to follow the above office policies.**

**Patient / Guardian Signature: _____ Date: _____**

**Printed Name of Patient: _____ Date: _____**