

Performance Chiropractic P.C.

St. Louis, MO 314-324-2645

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my patient Health Information will be used and agree to these policies and procedures.

Name of Patient

Date

Performance Chiropractic P.C.
St. Louis, MO 314-324-2645

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

The following is our financial policy, which we require you read, and sign prior to any treatment.

PAYMENT TERMS

Fees for services rendered are due at time of service. Doctor services that are in network will require payment as negotiated with each individual contract.

As a courtesy we can bill your insurance carrier and they will pay you directly.

Certain services provided by doctors and therapists at Performance Chiropractic are not reimbursable by your insurance company. The charges for these services will be your responsibility. I understand that certain services are not reimbursable by my insurance and that I will pay for such services as rendered.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of patient or responsible party

Date

Signature of co-responsible party

Date

Performance Chiropractic P.C.
St. Louis, MO 314-324-2645

Have you had a problem with any of the following?

Yes	No	Explain	
___	___	Eyes, Vision	_____
___	___	Ears, nose, throat	_____
___	___	Lungs, breathing	_____
___	___	Digestion	_____
___	___	Bowel movement	_____
___	___	Bladder problem	_____
___	___	Diabetes	_____
___	___	High blood pressure	_____
___	___	Cardiovascular problems	_____
___	___	Painful calves	_____
___	___	Stroke	_____
___	___	Headaches	_____
___	___	Balance problems	_____
___	___	Blackouts/fainting	_____
___	___	Numbness/tingling	_____
___	___	Psychological problems	_____
___	___	AIDS	_____
___	___	Cancer	_____
___	___	Arthritis	_____
___	___	Other conditions not listed	_____
___	___	Alcohol	___ drinks/week
___	___	Smoking	___ packs/day ___ # of years

Please list any allergies you are aware of: _____

Please list the medications you are currently taking.

Medication	Dose	Reason for medication

Please list any surgeries you have had.

Surgery	Year

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

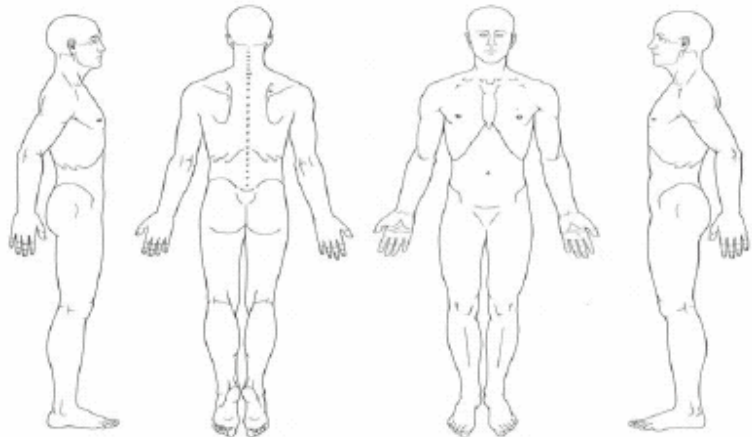
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

- ① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____ ② CT Scan date: _____
 ③ MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

- ① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ FT Student ⑥ Retired ⑦ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature _____ Date _____

Registration Information

Performance Chiropractic P.C.

St. Louis, MO 314-324-2645

Patient Information

---please print---

Patient _____ Date: _____
Last Name First Name Middle Initial

Address _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Birth date _____ Age _____ SSN# _____ Sex: M F

Single Married Widowed Separated Divorced

Spouse's Name: _____

Primary Care Physician: _____ Phone: _____

Address _____ Would you like a report of today's visit sent to them? Yes / No
City State

Occupation: _____ # of years _____ Employer Name: _____

Address _____
Street City State Zip

Employer Phone: _____ Best time to reach you: _____

Whom may we thank for referring you (where did you hear about us)? _____

Email Address: _____ Would you like to receive our email health newsletter? _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Consent to Services

I hereby authorize Dr. Doug Maxiner, and/or such associates or assistants as may be selected by him, to treat me by means of the following procedure: Examination, Massage, Manipulation, and or Physical Therapy

I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions which the above named doctor or associates or assistants may consider necessary or advisable in the course of the procedure.

For the purpose of advancing medical education, I consent to the admittance of observers to the treatment room.

The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I HAVE READ THIS CONSENT AND ITS CONTENTS HAVE BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS CONSENT AND THAT I AM SIGNING IT VOLUNTARILY AS MY OWN ACT AND DEED.

Signature

Date