



NEW PATIENT APPLICATION

Patient Name: _____ DOB: _____ Age today: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Marital Status: M D W S

Best phone number: _____ Best Method of Contact: Call , Text , Email .

Occupation: _____ Employer: _____ Night worker? Y / N

In case of an emergency, please contact: _____ Phone: _____

Relationship of emergency contact person to patient: _____

Were you referred by someone? _____

Internet search used? Insurance directory , Google , Yelp , Facebook , Other _____

Your Primary Physician or other practitioners that you see: _____

Purpose of this appointment: Pain Management/Injury , Nutritional Consult , Functional Medicine , Shockwave Tissue Regeneration , Free Consultation , Endo-Nasal Work , CranioSacral

MEDICAL HISTORY: Please print clearly and fill in as completely as possible.

Have you had Chiropractic care in the past? Yes No If yes, the most recent? _____

List any Current medications, natural supplements **AND** for what reasons or diagnoses?

1. _____ 3. _____

2. _____ 4. _____

Are you currently using any topical or internal form of hormone replacement therapy? Yes No

Name: _____ Time(s) of day applied: _____

List any **allergies** to medications, substances or foods: _____

Have you taken **antibiotics** within the last 5 years? Y / N Years ago? _____

Did you take antibiotics when you were a child? Y / N Details: _____

Have you ever suffered **TRAUMATIC** injury (Auto wrecks, Horses, Skiing, Snowboarding, etc)? Y / N

1. Year: _____ Age: _____ Details: _____

Were you evaluated and treated? Y / N Successful outcome? Y / N

2. Year: _____ Age: _____ Details: _____

Were you evaluated and treated? Y / N Successful outcome? Y / N

Any recent **NON-TRAMATIC** surgeries, procedures, hospitalization or injuries? Y / N

1. Year: _____ Age: _____ Details: _____

Were you evaluated and treated? Y / N Successful outcome? Y / N

2. Year: _____ Age: _____ Details: _____

Were you evaluated and treated? Y / N Successful outcome? Y / N

Put a "✓" check mark for self and/or "P" for Parents, "S" for Sibling, "G" for Grandparent. If self please note date of diagnosis or how long you have had the condition.

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism; Sober years? _____ | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> High Cholesterol (Statin Drug? Y / N) |
| <input type="checkbox"/> Anemia; Years? _____ | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hysterectomy; Full / Partial |
| <input type="checkbox"/> Autoimmune Diseases: _____ | <input type="checkbox"/> Intestinal Parasites |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) |
| <input type="checkbox"/> Cancer (type): _____ | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Leaky Gut Syndrome |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Mononucleosis (Mono) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Diabetes; Type 1 _____ Type 2 _____ | <input type="checkbox"/> Osteopenia, _____ Osteoporosis |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Eating Disorder _____ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Endometriosis Surgery/Year? _____ | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Gallstones Y/N Gallbladder Removed Y/N | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Genetic Disorder: _____ | <input type="checkbox"/> Thyroid Condition _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Viruses? Herpes, EBV (Mono), CMV, HPV |
| <input type="checkbox"/> Head Injury (year(s)): _____ | Other: _____ |
| <input type="checkbox"/> Hepatitis: A B C D | |

PERSONAL HEALTH HISTORY:

Smoke tobacco? Never smoked , Yes Per day? _____ Years? _____ When quit? _____

Partake in any recreational drug activity? Y / N If so, how often per day/week? _____

Do you feel refreshed after waking up? Y/ N How old is your mattress and pillow? _____

Your sleep position(s)? _____ How many hours of Sleep per night on average? _____

Do you wake at night consistently? What times? _____

What's the heaviest you have ever weighed? _____

Your birth by C-Section or Normal Any birth trauma? _____ Were you Breastfed? Y / N

Bowel movements per day? _____ Do you have to strain? Y / N Constipation at times? Y / N
Hemorrhoids? Y / N

Are you currently taking antacids? Y / N What Type? _____ For how long? _____

What are your stressors? _____

How do you relieve stress? _____

Are you happy with your current appearance? Y / N Are you happy with your abilities? Y / N

Tell us about any Hobbies, Special Skills, and Extracurricular Activities _____

Have you completed any food allergy tests? Y / N If yes, when? _____

Are you on a special diet? Y / N If yes which one(s)? _____ Use Energy Drinks? Y / N

Have you worked with a nutritionist or health coach before? If so, how long ago and for how long?

_____ Was it helpful? Y / N

When was the last time you went to the dentist? _____ Do your gums bleed sometimes? Y / N

Do you have any history of braces, root canals, abscesses, or sub-clinical infections? Please specify:

YOUR PERSONAL HEALTH GOALS:

3 months _____

6 months _____

1 Year _____

We offer many services which may be not be part of your current course of care with us.

Would you be interested in any of the following services?

Functional Medicine _____

Cranio-Sacral Therapy _____

Chronic Sinus Issues _____

Massage Therapy _____

Essential Oils Consult _____

Nutrition Counseling _____

Stress Management _____

Bio/Neuro Feedback _____

**Shockwave Tissue
Regeneration** _____

Signature _____

Date _____

Office Use: BP ___/___ O2 Sat ___ HR ___ Height ___ Weight ___
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INSURANCE INFORMATION

Do you have insurance coverage? Yes No
 Insurance Company Name: _____
 Responsible Party (person responsible for insurance/bill): _____
 Relationship of the responsible party (insured) to you: Self Spouse Other: _____
 Insured's Date of Birth: _____ ID # _____ Group # _____
 Provider ONLY Phone # _____ Type: HMO PPO EPA EPO KAISER

Were you involved in an Auto Accident? Yes No
 Work Injury? Yes No Date of Injury: _____
 Auto/WC Insurance Company: _____ Auto/WC Claim # _____
 Adjuster Name: _____ Adjuster Phone #: _____

Insurance is a method of receiving reimbursement for services rendered by a provider. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentage rates set by your contract with them. It is your responsibility to pay at the time of service any deductible, co-pay, or co-insurance fees not paid for by your insurance company. If you are being seen for a work or auto related injury it is your responsibility to provide our office with any and all information necessary to receive payment or it will become your financial responsibility to pay for services rendered.

ASSIGNMENT OF BENEFITS & CONSENT TO TREATMENT

I Hereby give permission to the doctor to release any information requested by my insurance company, physicians, or other health care providers acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services and I understand that all services are to be paid in full at the time of service. I hereby give permission to the doctor and/or therapist to administer treatment and perform such general procedures as he/she may deem necessary in the diagnosis and/or treatment of my condition. I fully understand that this consent will remain in effect until revoked in writing. I have and I do understand and agree to the above statements.

Patient Signature

Date

Signature of responsible party (if patient is a minor)

Date

Sound Body Health & Chiropractic

Cancellation / Missed Appointment Policy

In order to serve you better, please provide us with at least 24 hours notice if you will be unable to attend your appointment. This advance notice allows us to provide other patients awaiting an appointment the opportunity to receive care.

Our office runs on-time. If you miss an appointment without providing at least **4 hours** notice for Chiropractic and Functional Medicine appointments, and **12 hours** notice for Massage Appointments, you will be responsible for the below charges. We will do our best to accommodate you, however, arriving more than **5 minutes** late to an appointment may be considered a missed appointment depending on availability.

- **\$30 – Chiropractic appointment**
- **\$30 – Functional medicine Follow Up appointment**
- **\$45 – Report of Findings appointment**
- **\$42 – 1 hour massage appointment**
- **\$63 – 1.5 hour massage appointment**

I, (print your name or name of responsible party here) _____ agree to pay the appropriate late cancellation/no show fee if I fail to notify Sound Body Health & Chiropractic within the allotted time before my appointment.

Patient Signature

Date

Signature of responsible party (if patient is a minor)

Date

Sound Body Health & Chiropractic

Notice of Privacy Policy

INTRODUCTION

We are committed to treating and using protected health information about you responsibly. The Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. We are required by law to maintain the confidentiality of your individually identifiable health information. We are also required by the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your Protected Health Information (PHI).

We realize that these laws are complicated, but we must provide you with the following important information.:

- **How we may use and disclose your PHI**
- **Your privacy rights regarding your PHI**
- **Our obligation concerning the use and disclosure of your PHI**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice has posted a copy of our current notice in our office in a visible location at all times. You will be given the opportunity to review and/or receive a copy of the Privacy Practices upon request.

By signing this form below, I acknowledge the above terms of the Privacy Policies

Patient Signature

Date

Printed Name

Date

Signature of responsible party (if patient if a minor)

Date

Sound Body Health & Chiropractic Financial Policy Agreement

Thank you for choosing Dr. Peter Halvorson, DC, as your Chiropractic healthcare provider. We are committed to giving you the best care possible, and we want you to completely understand our financial policies. There are always ongoing changes in the healthcare industry, and these changes may affect you in the services that are covered by your insurance carrier, or in services that are determined to be due and payable directly by you. The following is a statement of our Financial Policy, which we require you to read and sign **prior to** any treatment.

- Payment is due at time of service unless arrangements have been made in advance. Your financial responsibility to us will be your cash fee (if you do not have insurance coverage), co-payments and the amount your insurance company deems your responsibility such as deductibles and coinsurance, and denials for services not covered under your policy. We accept cash, checks, and credit cards. Please note if paying by check, all dishonored or returned checks are subject to a \$30 charge to your account.
- Keep in mind that your insurance policy is basically a contract between you and your insurance company and as the patient, you are ultimately responsible for the payment for services rendered. As a service to you, we file your insurance claim and the insurance company usually pays us directly. Please bring your insurance card and personal identification to each appointment.
- Due to the multiplicity of insurance plans, we are unable to know each carrier's reimbursements and what procedures apply to your deductible and what does not. It is your responsibility to contact your insurance carrier directly for your specific benefits.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon the receipt from our office.
- The billing department will file your Medicare Claims. Medicare supplemental insurance is billed as a courtesy to you. If no payment is received from your supplemental insurance within sixty days of filing, the balance becomes your responsibility, and we will bill you.
- Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency or small claims court. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay your account in full before scheduling another appointment if your account is in collections.
- In the instance of prepayment for service, should care be discontinued at any point, a prorated refund will be issued. If financial arrangements were made, and care is discontinued at any time, payment is still due for services rendered.

I have read and understand the above FINANCIAL POLICY AGREEMENT, and I agree to be bound by its terms.

Name of Patient (PLEASE PRINT)

Date

Signature of Patient (or responsible party if minor)

Date

Sound Body Health & Chiropractic

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physiotherapy, physical medicine, etc. on me by the doctor of chiropractic and/or other assistants and/or licensed practitioners.

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, headaches, and temporary transient worsening of symptoms. More serious complications are extremely rare, but do occur. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications. However, I wish to rely upon the doctor to exercise the best judgement during the course of the procedure(s), which the doctor feels at the time, based upon the facts then known, that are in my best interest. I also understand that I will be given an explanation of the procedures to be rendered, any alternatives available to me, relative risks for specific procedures, and any questions I have will be welcomed, appreciated, and answered to the best of the physician's ability.

I will receive the majority of my care under the supervision of the attending physician licensed to provide chiropractic care. However, there may be times that it will be clinically warranted to have the therapy provided by the attending massage therapist, limited to the scope of their license to provide care. By my signature, I give permission for my attending physician and the licensed massage therapist to discuss my care as needed in order to provide complete clinical care.

I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, the doctor reserves the right to terminate a doctor-patient relationship for non-compliance and/or other reasons that affect the doctor-patient relationship. I also understand that there is no guarantee or warranty for specific care results.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature

Date

Guardian Signature (if patient is a minor)

Date