

The Alternative Wellness Center

Chiropractic Care • Massage Therapy • Kinesio Tape • Nutritional Counseling • Weight Management

PLEASE PRINT CLEARLY and FILL IN COMPLETELY

Print Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ Age _____ Email _____
 Home Phone (____) _____ Cell Phone (____) _____
 Please Check: Male Female; Right handed Left handed; Single Married Widowed Divorced
 Employer _____ Occupation _____
 Employer's Address _____ Phone (____) _____
 Prefer to receive calls at: Home Cell Work No preference
 Spouse/Parent's name _____ Employer _____
 Children (name and age) _____
 In case of an emergency, who should be notified? _____ Phone (____) _____
 Whom may we thank for referring you to? _____

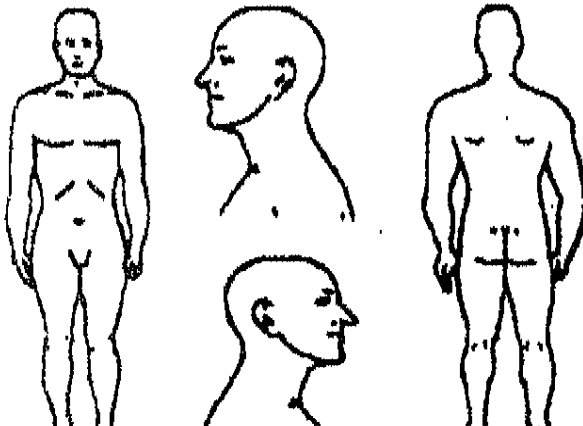
RESPONSIBLE PARTY If patient is under the age of 18

Name of person responsible _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Name of Employer _____ Phone (____) _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Date of Birth _____
 Relation to Patient _____ Phone (____) _____
 Address _____ City _____ State _____ Zip _____
 Employer _____ Occupation _____
 Employer's Address _____ Phone (____) _____
 Member/Contract ID # _____ Group # _____ Effective Date _____
 Other dependents covered/listed under this plan _____
 How much is your deductible? _____ How much of your deductible has been used? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW Have you suffer from any of the following?



- | Past | Present | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Backaches |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Heart Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Digestive Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Painful Menstrual Cycle |

***WHAT IS YOUR MAJOR COMPLAINT?** _____

How did this problem begin (fall, lifting, etc.)? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your conditions (working, exercise, etc.)? _____

What relieves your condition (ice, heat, massage, etc.)? _____

Other doctors who treated this condition? _____

How long has it been since you felt really good? _____

How often do you experience your symptoms? Constantly Frequently Occasionally Intermittently

Please circle the nature of you symptoms: Sharp Dull Numb Burning Shooting Tingling
Radiating Pain Tightness Throbbing OTHER: _____

Please rate your pain on a scale of 0 to 10 (0 – no pain and 10 – excruciating pain): _____

Please rate how your symptoms affect your abilities to perform daily activities? _____

Please circle daily work habits: Sitting Standing Light/Heavy labor Computer work OTHER: _____

Are you pregnant? Yes No Due Date: _____

Other complaints: _____

Have you ever been in a motor vehicle accident? Yes No When? _____
Where you injured? Yes No Describe: _____

Have you had any personal injuries or accidents? Yes No When? _____
Describe: _____

Please list surgical dates and operations: _____

Is there a current health condition? _____

Is there a family history of: Heart Disease Cancer Stroke Other: _____

Date of most current physical examination: _____

Do you exercise? Yes No Describe form(s) and how often: _____

Please list vitamins/supplements currently taking: _____

Please circle any of the following drugs currently taking: Nerve pills Muscle Relaxers Pain killers
Tranquilizers Birth control OTHER: _____

Please list any allergies: _____

Sleeping position: Back Sides Stomach Do you wear: Heel lifts Arch support/Orthotics

Do you smoke? Yes No How many on a daily basis? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Have you had chiropractic care? Yes No When? _____ Why? _____

I hereby instruct my insurance company/attorneys to make payments for services rendered directly to:
The Alternative Wellness Center, Dr. Antonio Gonzales DC
920 Lambert St Niles, MI 49120

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee. I further agree that I will pay, in a current manner and said balance of professional service charges over and above this insurance payment. A photocopy of this agreement shall be considered as effective and valid as the original document. I authorize the release of any information to my case to all insurance carries, adjusters, or attorneys directly involved with my case.

Signature: _____ Date: _____ Witness: _____ Date: _____

The Alternative Wellness Center

Chiropractic Care • Massage Therapy • Nutritional Counseling
Personal Fitness Training • Kinesio Taping

Informed Consent for Chiropractic Care

When a patient seeks chiropractic care and we accept that patient, it is essential for both to be working towards the same objective. It is important each patient understand the care plan, objective, and method(s), which will be applied and used to attain it. As a patient, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided. It's our priority to advise you of the known benefits, risks, and alternatives as well so that you may make a decision whether or not to follow through with chiropractic care.

A chiropractic manipulation is the specific application of forces to correct the structure of the spine, and the function of the nerve system primarily. Adjustments are most often manually performed, but also may be done with a handheld activator. Ancillary procedures such as physiotherapy and/or rehabilitative procedures could be included as well.

If ever under our care we encounter non- chiropractic or unusual findings, we will immediately direct you to seek the services of another health care provider to help address those findings.

Please read the following carefully, then print, sign, and date if you agree:

All questions in reference to the doctor's objective in regards to my care at The Alternative Wellness Center have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care.

Patient Name: _____

Patient Signature: _____ Date: _____

Consent to evaluate and adjust a minor:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release for X-Ray:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x- ray evaluation. I have advised that x- ray can be hazardous to an unborn child. Date of last cycle: _____

Patient Signature: _____ Date: _____

The Alternative Wellness Center

Chiropractic Care Massage Therapy Nutritional Counseling

Personal Fitness Training Kinesio Taping

Privacy Policy Consent

The Alternative Wellness Center provides this consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

We understand that your medical information is personal to you and we are committed to protecting your information. As our patient, we create medical records about your health and our services/items provided to you. By law, we are required to make sure your health information is kept private.

If you ever believe your privacy rights have been violated, you may file a complaint with the Business Office Manager or Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

In signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent (must be in written format including your original signature). This withdrawal will not affect any disclosures we have already made in confidence to your initial consent. The Alternative Wellness Center may condition treatment upon the execution of consent.

In signing this form, you acknowledge that you are representing yourself as a patient. If you are under that age of 18, your parent or legal guardian signing acknowledges that he or she is representing you as the patient. This means you authorize the doctor(s) and staff to administer and perform all treatments and diagnostic procedures considered necessary to help with the care at our facility.

This information and Notice of Privacy Practices will be made upon request.

Patient Name: (print) _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____

MISSED APPOINTMENT AGREEMENT

Thank you for choosing the Alternative Wellness Center for your chiropractic care. Trying to accommodate every patient's individual needs and schedules can be difficult, but we always do our best. We work very hard to stay on schedule so our valuable patients do not have to spend time waiting for their appointments.

A scheduled appointment is a commitment of time agreement between you and our practice. We reserve that time just for you. When appointments are missed or cancelled that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last-minute cancellation.

In order to provide the highest quality services to our patients, we have enforced a Missed Appointment Policy. Please review the following and sign in confirmation that you understand our policy.

As a patient or a guardian for a patient receiving services from the Alternative Wellness Center, I understand and agree to the following:

***I am responsible for cancelling appointments at least 4 hours prior to the appointment.**

***Should I fail to attend or cancel my appointment within that 4 hour period I will be assessed a \$40 missed appointment fee.**

***Appointments missed due to illness, adverse weather conditions or other circumstances which prevented me from being able to attend will not be considered missed appointments. I MUST notify the Alternative Wellness Center of such an occurrence.**

***The Alternative Wellness Center may terminate my services due to noncompliance if I have missed too many appointments; this limit is three missed appointments in a twelve month period. The Alternative Wellness center will notify me if should noncompliance result in termination of services.**

PATIENT NAME _____

PATIENT/GUARDIAN
SIGNATURE _____

DATE _____



THE ALTERNATIVE WELLNESS CENTER

920 Lambert St. Niles, MI 49120

Massage Therapy Cancellation Policy

If you are unable to keep your massage appointment, it will be necessary for you to contact our office within 24 hours of your scheduled appointment - emergency circumstances will be evaluated on an individual basis.

Those who do not give a 24-hour notice will be billed for the services of that appointment as follows - \$40 for a half-hour massage; \$65 for an hour massage; or \$90 for an hour-and-a-half massage.

All missed-appointment charges are nonbillable to insurance and must be paid in full BEFORE scheduling your next massage appointment.

I understand and agree to the Massage Cancellation Policy at The Alternative Wellness Center.

Patient's Name

Date

Patient's Signature

Date

Patient's Guardian's Signature

Date

