Matthew Teusink, D.C.

Patient Name: _____ **Today's Date:** _____

Address: _____

City, State, Zip Code: _____

H. Phone: _____ **W. Phone:** _____ **Cell Phone:** _____

Email Address: _____

Sex: M F **Marital Status:** M S D W **Date of Birth:** _____/_____/_____ **Age:** _____

Social Security #: _____

Occupation: _____ **Employer:** _____

Have you ever received Chiropractic Care? Yes No **If yes, when?** _____

Name of most recent Chiropractor: _____

1. **Reasons for seeking chiropractic care:**

Primary reason: _____

Secondary reason: _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

_____

3. **Past Health History:**

- **Please indicate if you have a history of any of the following:**

□ Anticoagulant use
□ Bipolar disorder
□ Bleeding problems
□ Cancer
□ Diabetes
□ Heart problems/high blood pressure/chest pain
□ Lung problems/shortness of breath
□ Major depression
□ Schizophrenia
□ Stroke/TIA's
□ Other _____
□ None of the above

- **Previous Injury or Trauma:**
  ___

- **Have you ever broken any bones? Which?**
  _____

- **Allergies:** __

C. Medications:

Medication Name:	**Reason for taking:**
_____	_____
_____	_____
_____	_____

D. Surgeries:

Date:	**Type of Surgery:**
_____	_____
_____	_____
_____	_____
_____	_____

E. Females/Pregnancies and Outcomes:

Pregnancies/Date of Delivery:	**Outcome:**
_____	_____
_____	_____
_____	_____
_____	_____

4. **Family Health History:**

Do you have a family history of? (Please check all that apply)

□ Adopted/Unknown	□ Diabetes	□ Strokes/TIA's
□ Cancer	□ Headaches	□ Other _____
□ Cardiac disease	□ Neurological diseases	□ None of the above
□ Cardiac disease below age 40	□ Psychiatric disease	

Deaths in immediate family: _____

Cause of parents or siblings death:	**Age at death:**
_____	_____
_____	_____
_____	_____
_____	_____

Social and Occupational History:

Job description: _____

- **Work schedule:** _____
- **Recreational activities:** _____
- **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** _____

_____

Matthew Teusink, D.C.

REVIEW OF SYSTEMS
Below please indicate if you have any of the following:

PULMONARY
□ Asthma/difficulty breathing
□ COPD
□ Emphysema
□ Other _____
□ None of the above

CARDIOVASCULAR
□ Angina/chest pain
□ Congestive heart failure
□ Heart attacks/MIs
□ Heart disease/problems
□ Heart surgeries
□ Hypertension
□ Irregular heartbeat
□ Murmurs or valvular disease
□ Pacemaker
□ Other_____
□ None of the above

NEUROLOGICAL
□ Headaches
□ History of seizures
□ Loss of sense of smell
□ Memory loss
□ Strokes/TIAs
□ Tremors
□ Vertigo
□ Visual changes/loss of vision
□ One-sided decreased feeling in the face or body
□ One-sided weakness of face or body
□ Other _____
□ None of the above

ENDOCRINE
□ Diabetes
□ Hormone replacement therapy
□ Injectable steroid replacements
□ Thyroid disease
□ Other _____
□ None of the above

RENAL
□ Bladder Infections
□ Dialysis
□ Difficulty urinating
□ Hematuria (blood in the urine)
□ Incontinence
□ Kidney disease
□ Renal calculi/stones
□ None of the above
□ Other_____

GASTROENTEROLOGICAL
□ Bloody or black tarry stools
□ Bowel incontinence
□ Constipation
□ Difficulty swallowing
□ Frequent abdominal pain
□ Gastroesophageal reflux/ heartburn
□ Hepatitis or liver disease
□ Hiatal hernia
□ Irritable bowel/colitis
□ Nausea
□ Pancreatic disease
□ Ulcerative disease
□ Vomiting blood
□ Other _____
□ None of the above

HEMATOLOGICAL
□ Abnormal bleeding/bruising
□ Anemia
□ Anticoagulant therapy
□ Enlarged lymph nodes
□ Hemophilia
□ HIV positive
□ Hypercoagulation or deep venous thrombosis/ history of blood clots
□ Regular use of NSAIDs (Ibuprofen, Asprin, Naproxen, etc.)
□ Sickle-cell anemia
□ Other_____
□ None of the above

DERMATOLOGICAL
□ Psoriatic disorders
□ Significant burns
□ Significant rashes
□ Skin grafts
□ Other _____
□ None of the above

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.*

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor Teusink. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.
I understand, and I am informed that, there are some risks to chiropractic examination and treatment including, but not limited to:

- fractures (broken bones)
- increased symptoms and pain
- spinal or disc injuries
- no improvement of symptoms or pain
- dislocations
- stroke
- sprains/strains

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

Revised April 2015

Matthew Teusink, FIAMA

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, American Express, cash or check.
- Your insurance policy is a contract between you and your insurance company. **As a courtesy**, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; **however, you remain responsible for charges to any service rendered**. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Printed Name of Witness: _____

Reviewed April 2008

The Privacy Pledge
Of Matthew Teusink, D.C., Fountain Hills, Arizona

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal and health information to bill your Health Insurance Company or third party insurance. We may use an outside billing company to accomplish this task.

Our complete Notice of Privacy Practices for Protected Health Information is located in the reception area of this office. This notice provides a detailed description of how health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practice as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to use at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed name	Authorized Provider Representative
_____	_____
Signature	Date