It's time to feel better!

Dr. Katherine Iacuone and Dr. Dave Iacuone want to thank you for choosing Desert Valley Chiropractic for your healthcare needs. We are excited that you have made the choice to join our practice and we are looking forward to helping you achieve greater health through chiropractic.

We always want to show our appreciation to those that refer their family and friends. Please take a moment and check the appropriate box below indicating how you were first introduced to our office:

- ❑ **Friend** ________________________________ Please specify name
- ❑ **Patient** ________________________________ Please specify name
- ❑ **Relative** ________________________________ Please specify name
- ❑ **Online** ❑ **Google** ❑ **Yelp** ❑ **Zocdoc** ❑**Other**____________________
- ❑ **Insurance company**________________________
- ❑ **Walk –In**
- ❑ **Other** ________________________________

____
Please print your Name

____
Patient's signature

Thank you again for choosing Desert Valley Chiropractic!

Patient Health History

Today's Date [ ] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________ **Nick Name**______________________

Last Name ______________________ **Middle Name** ______________**Suffix** ________

Address 1 ____

Address 2 ____

City______________________ **State**__________ **Zip Code** ______________

Primary Phone ______________________ **Mobile Phone** ______

Would you like to receive text Reminders? ❑ Yes ❑ No

Who is your cell phone carrier? ______________________

Email ______________________ **Can we leave a voicemail?** ❑ Yes ❑ No

Date of Birth __________ **Age** ___ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

SSN ______________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Current medications, including dosage if known.

If there are no current medications, check here: ❑

1) ______________________ **4)** ______________________
2) ______________________ **5)** ______________________
3)______________________**6)**______________________

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind?

❑ Type I ❑ Type II - ***If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?***

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________

Have you had an X-ray or CT scan or MRI in the last 2 years?

❑ Yes ❑ No If yes, please explain: ______________________

Height: ______inches **Weight:** __________pounds **BP:** ______ / ________

Is this injury or illness related to an automobile accident? Y N

If yes, Name of: Auto Ins. Co. ___________________________________

Policy # __________________________ Claim # ______________________________

Agent's Name____________________________ Agent's Phone # ___________________________

Address: ____

City_________________________________ State ____________ Zip Code ________________

Were you considered at fault? Y N

Is this injury or illness work-related? Y N

Primary Care Physician

Name____

Address____

May we send your initial note with diagnoses and care plan to your PCP? ❑ Yes ❑ No

Signature: ___________________________________

❑ Major Medical Insurance ❑ Self- Pay

Primary: ____

Group#_____________________________________ID__________________________________

List an emergency contact and phone number:

____

AUTHORIZATION TO RELEASE INFORMATION

To: Drs. Katherine and David Iacuone
You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Desert Valley Chiropractic for any services furnished by Drs. Katherine and David Iacuone. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim.

Non-Medicare Patients

In consideration of services to be rendered, I hereby assign and transfer to Desert Valley Chiropractic any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or P.I.P., Medpay for the payment of such services rendered. I agree to cooperate, aid and assist Desert Valley Chiropractic in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I further assign and transfer to Desert Valley Chiropractic an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.

I UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES ANY CLAIMS FOR MY CARE THAT I WILL ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Please note that a signature below is required in order to receive treatment, if you have any questions or concerns we would be happy to discuss them with you.

Patient Signature:

______________________________ (If patient is a minor, a parent's signature is required)

______________________________ (Responsible party)

Witness ______________________________ Date ______________________________

Desert Valley Chiropractic

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I UNDERSTAND THAT IF MY INSURANCE COMPANY DENIES ANY CLAIMS FOR MY CARE THAT I WILL ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Please note that a signature below is required in order to receive treatment, if you have any questions or concerns, we would be happy to discuss them with you.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature:______________________________________ Date:________________

Name:____

PATIENT OPTIONS ACCESS PROGRAM FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions, is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

· The Program provides discounts to you from contracted healthcare providers for services rendered;

· The Program participant is obligated to pay for all healthcare services directly to provider but will receive a discount from healthcare providers who have contracted with Patient Options;

·This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where a third party insurance company is responsible for charges.

· Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;

· The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

I have read and agree to the terms and conditions set forth above:

Name:________________________________ Signature:________________________________

Address:____________________________________ Date:__________________

____

____

**Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

1.________________________________ 2.________________________________

3.________________________________ 4.________________________________

5.________________________________ 6.______________________

Patient Name: ________________________________ **Date:** ________________________________

Surgery (Please include all surgery)

(1) Type____________________________________When______________________

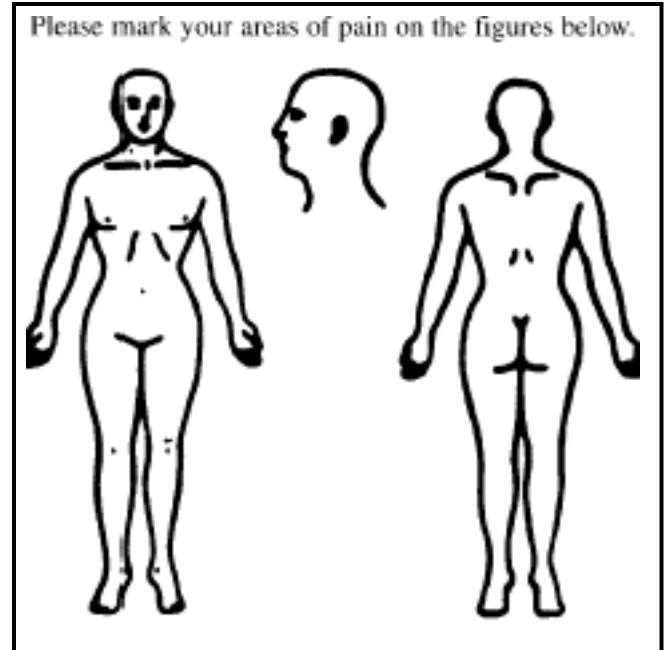
(2) Type____When____________________________

(3) Type____When____________________________

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

☐Stroke
☐Pacemaker
☐ High blood pressure
☐ Heart Attack
☐ Cancer
☐Heart disease
☐ Diabetes
☐Shingles
☐Dizziness
☐ Pregnant at this time

☐ Arthritis
☐Numbness or pain in arms/legs/hands
☐Pain between shoulders
☐Swollen Joints
☐ Migraine
☐ Spinal curvature
☐ Stiff Neck
☐ Headache
☐Sinus Problems
☐Backache



0 ———————— 5 ———————— 10

Please rate your pain: 0 Absent -- 10 Extreme

What is your main area of concern____

On a Scale of 1-10 (10 being extreme pain) what is your pain level on **average**? ___________________

On a Scale of 1-10 (10 being extreme pain) what is your pain level at the **worst**? _____________________

Are symptoms: □ Getting Worse □ Getting Better □ Staying the same

How did the pain begin? □ Gradual □ Sudden

Please explain: ____

How long has pain been present? ____________________________

How often do your symptoms occur? Daily Weekly Monthly

Occasional (0–25%)____ Intermittent (25– 50%)_____ Frequent (50– 75%)_____ Constant (75– 100%)_____

When are your symptoms worst? Morning ______ Afternoon ______ Evening ______

Do your symptoms wake you up at night? Y N

Do your symptoms remain local? Y N

Do your symptoms radiate? Y N Left leg Right leg Left arm Right arm Back of head

Describe your symptoms? Dull ___ Sharp __ Burning___ Deep ___Ache __ Stabbing __ Tingling___ Other ________

Are your symptoms aggravated by: Sitting___Standing____Bending____Coughing____Sneezing___

Movement __ Straining ___ Reaching___ HouseChores____Other ____

Are your symptoms relieved by: Sitting___ Standing___ Lying____ Exercise____ Ice ___Rest ___ Heat ____

Stretching ____ Nothing ____ Other____