

Bella Vita Chiropractic & Wellness
610 Eastbury Drive Suite 3 Iowa City, IA 52245 (319) 887.6992

Patient Data _____ **Date:** _____

Title: Mr. Mrs. Ms Miss (check one)

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Date of Birth: ____/____/____ **Sex:** Male Female **Email:** _____

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Full Time Student Part Time Student Other (check one)

Spouse Data _____

Is your spouse a patient in the clinic? Yes No **Spouse's Date of Birth** ____/____/____

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Employer Data _____

Name: _____

Address Line 1: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact _____ **Physician's Name:** _____

Contact Name: _____

Contact Phone: (_____) _____ - _____

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Is it okay to call you at work?

- Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|----------------------------------------|-------------------------------------------|--------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

- | | | | |
|---------------------------------------|----------------------------------------------|----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|--------------------------------------------|---------------------------------------------------|--------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |

Allergies:

- | | | | |
|-------------------------------|---------------------------------------------|------------------------------------------|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | |

Social History:

- | | | | |
|-------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Use:

- | | | | |
|----------------------------------------------|-------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children:

- | | | |
|----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|----------------------------------------|-----------------------------------------|-----------------------------------------|

Female Children:

- | | | |
|----------------------------------------|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|----------------------------------------|-----------------------------------------|-----------------------------------------|

Occupational Activities:

- | | | | |
|-----------------------------------------|---------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |

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By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

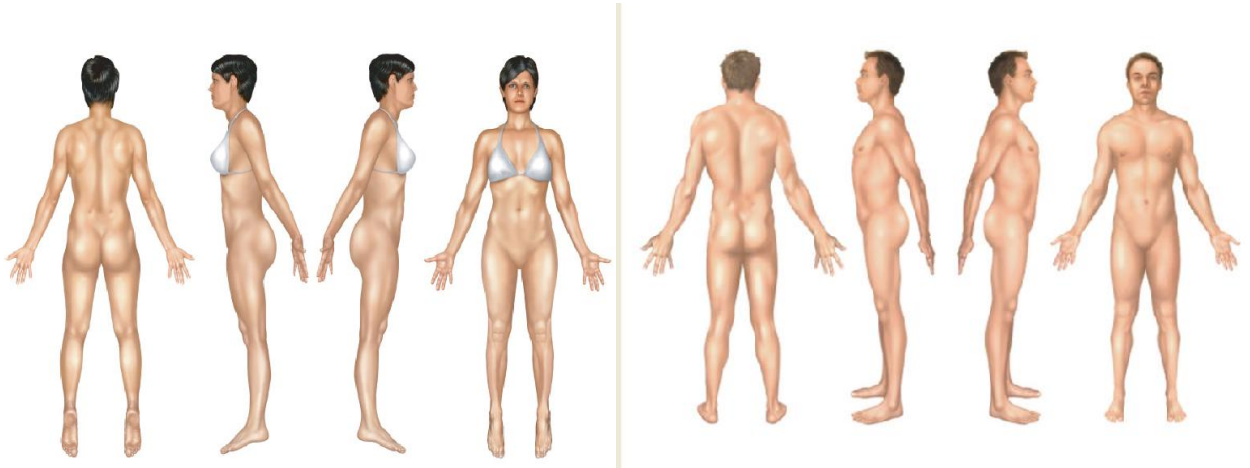
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ **Day** _____ **Year** _____

How did your symptoms begin? _____

Patient Health Information Consent Form

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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. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for 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 the use of 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 I agree to these policies and procedures.

Name of Patient

Date

Informed Consent

The primary treatment used by doctors of chiropractic is the spinal manipulation or spinal adjustment.

- **The nature of the chiropractic adjustment:**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This adjustment may cause an audible “pop” or “click” much like when you “crack” your knuckles. You may or may not feel or sense movement.

- **The material risks inherent in chiropractic adjustments:**

As with any healthcare procedure, there are certain complications which may arise during a chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of risks occurring:**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and physical examination or x-rays is medically necessary. Stroke has been the subject of tremendous disagreement within and without the profession; however, the fact remains that the incidence is extremely rare. Despite the rarity of the occurrence of a stroke we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

- **The risks and dangers attendant to remaining untreated**

- Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic and adjustment and related treatment. I have discussed it with Dr. Jordan M. DeGrazia and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to receive care.

Date: _____

Printed Name: _____

Signature: _____

Signature of Parent or Guardian: _____

I have read and understand the payment policy of Bella Vita Chiropractic & Wellness and Longevity Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Bella Vita Chiropractic & Wellness or Longevity Chiropractic and my insurance company. I request that Bella Vita Chiropractic & Wellness or Longevity Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. DeGrazia at Bella Vita Chiropractic & Wellness, or Dr. Brink at Longevity Chiropractic that fees will be due and payable immediately.

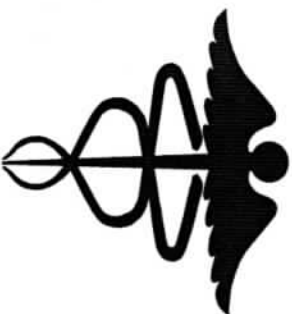
Patient's signature (or guardian if patient is a minor)

Date

Witness

***Bella Vita Chiropractic & Wellness
&
Longevity Chiropractic***

FINANCIAL POLICY



Chiropractic care is covered under many insurance plans. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

Bella Vita Chiropractic and Wellness and Longevity Chiropractic offer a 20% Time of Service Reduction in payment for those patients without coverage. We are happy to accept cash, check, Master Card, Visa or Discover.

GROUP OR INDIVIDUAL INSURANCE

Bella Vita Chiropractic and Wellness and Longevity Chiropractic are participating providers for Blue Cross and Blue Shield (the PPO plans) and several other commercial plans. Coverage, co-payments, co-insurance and deductibles vary with each plan. We will attempt to verify your coverage and patient responsibility at the time of your visit. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles, co-pays or co-insurance. Any questions concerning your coverage may be directed to your insurance company. For those insurance plans in which we do not participate, you may want to verify if you qualify for out-of-network benefits by contacting your insurance company.

"ON THE JOB" INJURY (Worker's Compensation)

Employers typically have authorized practitioners that work with their worker's compensation insurance company. You will need to contact your employer to find out their specific protocol. If Bella Vita Chiropractic and Wellness or Longevity Chiropractic is approved to provide care, you will need to provide us with the name and address of the insurance carrier and/or adjuster.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. The benefits quoted by the insurance company are not a

guarantee of payment. Notify our insurance department immediately of the insurance information needed for billing and if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for the settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately. We will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MEDICARE

We do not accept assignment from Medicare. Any insurance reimbursement is sent directly to our patients. You are required to pay the deductible as well as the limiting charge and any non-covered services at time of service. Our office completes and files the claims for Medicare at no charge.

MEDICAID

Bella Vita Chiropractic and Wellness does not participate with Medicaid of Iowa or any other state. Longevity Chiropractic participates with Medicaid of Iowa.