Balancing Point
Center for Wellness, PC

Confidential New Patient Form

NAME: _____ **SS#:**_____ **DATE:** _____

HOME ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

HOME #: (_____) _____ **CELL:** (_____) _____

D.O.B.: _____/_____/_____ **AGE:** _____ **MARITAL STATUS:** S P M D W

EMAIL: _____ **HOW'D YOU HEAR ABOUT US?** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER ADDRESS & NUMBER: _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

HOME NUMBER: _____ **WORK NUMBER:** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with: (insurance company) _____ and assign directly to Dr. Kristina Chung; all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed for one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____
Please **print** the name of Patient, Parent, Guardian, or Personal Representative

INSURANCE INFO –* FILL OUT ONLY IF YOU ARE NOT THE PRIMARY CARD HOLDER**

INSURANCE NAME: _____ **POLICY #:** _____

GROUP#: _____ **RELATION TO INSURED:** _____

INSURED'S NAME: _____ **INSURED'S D.O.B.:** _____/_____/_____

INSURED'S PHONE #: _____ **INSURED'S EMPLOYER/SCHOOL:** _____

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Patient History Form

PATIENT CONDITION

Present Complaint/Reason for Seeking Care in this Office:

Reason for Visit: _____

Pain or Problem started on:_____

Pains are: O Sharp O Dull O Throbbing O Intermittent O Numbness
O Aching O Tingling O Stabbing O Shooting O Other: _____

Does this pain shoot, radiate, or travel in your body? O No O Yes:_____

Are you experiencing numbness or tingling in any area of your body? O No O Yes: _____

Since the pain began, is it: O Same O Better O Worse

What makes the problem better? O Nothing O Lying Down O Standing O Walking O Sitting O Movement
O Exercise O Inactivity/Rest O Other _____

What makes the problem worse? O Nothing O Lying Down O Standing O Walking O Sitting O Movement
O Exercise O Inactivity/Rest O Other _____

Can you perform your daily home activities? O Yes O Only with help O Not at all

Do you exercise? O Yes, almost daily O Yes, occasionally O Not at all

Can you perform your daily work activities: O Yes, all activities O Only some O Not at all

Is this condition worse during certain times of the day?_____

Is this condition interfering with: O Work O Sleep O Routine O Other: _____

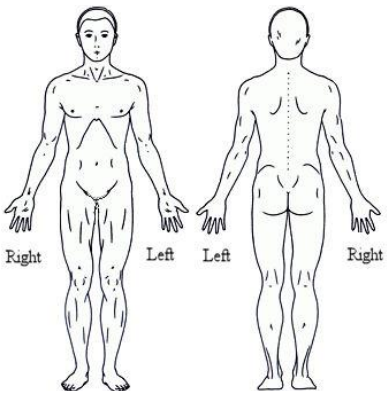
Is this condition progressively getting worse?_____

Other doctors seen for this condition_____

Any home remedies? _____

Using the symbols below, mark on the pictures where you feel pain:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



On a scale of zero to 10,
I rate my discomfort as follows:

Neck-Shoulder-Arm-Pain
|_____|
0 10
no pain **severe pain**

Mid Back Pain
|_____|
0 10
no pain **severe pain**

Low Back and Leg Pain
|_____|
0 10
no pain **severe pain**

GENERAL HEALTH HISTORY

Have you ever seen a chiropractor before? ☐No ☐Yes
Reason: _____

What treatments have you already received for this condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic
☐ None ☐ Other: _____

Name of Doctor(s) who have treated you: _____

Date of Last: Physical Exam: _____ Spinal Exam: _____ Blood Test: _____
Chest X-Ray: _____ Spinal X-Ray:_____ Urine Test: _____
Dental Exam: _____ MRI, CT Scan, Bone Scan: _____

Please turn the page over →

GENERAL HEALTH HISTORY CONTINUED.

For the conditions below, mark with a (√) if you ever **HAD** it or **HAVE** it presently.

Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Angina	☐	☐	Diabetes	☐	☐	Jaw pain/TMJ	☐	☐	PMS
☐	☐	Anorexia	☐	☐	Depression/Anxiety	☐	☐	Liver Problems	☐	☐	Prostate Problems
☐	☐	Aortic Aneurysm	☐	☐	Digestive Disorders	☐	☐	Kidney Disorders	☐	☐	Rapid Heartbeat
☐	☐	Arthritis	☐	☐	Dizziness/Fainting	☐	☐	Loss of Bladder Control	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Nervousness	☐	☐	Pregnancies
☐	☐	Bladder Infection	☐	☐	Epilepsy	☐	☐	Pacemaker	☐	☐	Scoliosis
☐	☐	Blood Disorder	☐	☐	Fatigue	☐	☐	Pain-Neck	☐	☐	Stiff Joints
☐	☐	Breast Lump	☐	☐	Gall Bladder Problems	☐	☐	Pain- Mid Back	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Headache/Migraine	☐	☐	Pain- Low Back	☐	☐	Swelling in joints
☐	☐	Chest Pain	☐	☐	Heart Disease/Attack	☐	☐	Pain- Arm/Elbow	☐	☐	Tinnitus (Ear Noises)
☐	☐	Chronic Cough	☐	☐	Heartburn/Indigestion	☐	☐	Pain- Hand/Wrist	☐	☐	Tuberculosis
☐	☐	Chronic Sinusitis	☐	☐	Herniated Disk	☐	☐	Pain- Shoulder	☐	☐	Ulcer
☐	☐	Colitis	☐	☐	High Blood Pressure	☐	☐	Pain- Ankle/ Foot	☐	☐	Vision Disturbances
☐	☐	Convulsions	☐	☐	High Cholesterol	☐	☐	Pain- Leg/Knee	☐	☐	Venereal Disease

Injuries/Surgeries	**Description:**	**When did it happen?**	**Imaging? Findings?**
Falls:			
Head Injuries:			
Broken Bones:			
Dislocations:			
Surgeries:			

Medications
What are you taking and what is it for?
_____
_____
_____

Allergies
Do you have any allergies?
(Seasonal, pets, foods, medications, etc.)
_____
_____

Vitamins
Do you take any vitamins, minerals or herbs:
_____
_____
_____

FAMILY HISTORY

Please mark if any of your family members have HAD or HAVE the following conditions:

	Mom		Dad		Brother		Sister	
	Had	**Have**	**Had**	**Have**	**Had**	**Have**	**Had**	**Have**
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, type: _____	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack/Stroke	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐
Neurological Problems	☐	☐	☐	☐	☐	☐	☐	☐
Seizure/Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Issues /Ulcers	☐	☐	☐	☐	☐	☐	☐	☐

Family Information

Child Name	Sex	D.O.B.	Age
	M F		
	M F		
	M F		
	M F		

Deaths in the Family
List any deaths in the family including grandparents, aunts, uncles, etc...:

Relationship	Cause	Age

SOCIAL HISTORY

Exercise
How often do you exercise?
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

What does your exercise consist of?
_____
_____
_____

Work Activities
What is your usual work position?
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

What do you do at work?
_____
_____
_____

Habits
- ☐ Smoke: _____ Packs a Day
- ☐ Alcohol: _____ Drinks a Week
- ☐ Coffee: _____ Cups a Day
- ☐ Soda/Caffeine: _____ Cups a Day
- ☐ High Stress Level

Reason for stress level?
_____
_____
_____

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Consent and Statement of Financial Responsibility

1. **FOR CHARGES BILLED TO INSURANCE.** ***I agree Balancing Point will charge the credit card on file for services NOT reimbursed by my insurance carrier after 45 days***. Balancing Point will collect my outstanding balances including co-pays, co-insurance, deductible and non-covered services from the credit card on file and will refund over-payments (if any) tothe credit card on file.
2. **APPOINTMENT ATTENDANCE AGREEMENT/ FEES.** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I will I agree to provide a 24 hour notice in advanced when I need to cancel an appointment and that cancellation less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25 per each service. I acknowledge that if I make a payment by check that has insufficient funds, I will authorize Balancing Point to collect the non-payment PLUS $50 returned check fee to the credit card on file
3. **ACKNOWLEDGEMENT FOR NON-COVERED SERVICES.** I acknowledge that my health insurance plan requires me to be responsible for Co-payments, Co-insurance and deductibles for covered services as well as those services that exceed benefit limits. I also agree that I'm financially responsible for all products and services that are considered may not be considered non-payable by my insurance company such as vitamins and wellness care, acupuncture, maintenance care, supplements and supports. I acknowledge I have been advised with the information below, and that I agree to be financially responsible for services and products rendered outside of my coverage limitations.
4. **RESPONSIBILITY FOR PAYMENT.** I acknowledge that in consideration of the services provided to me by Balancing Point Center for Wellness, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to understand with any current insurance information and familiarize myself with my insurance plan and policies and that it does not guarantee payment. Any questions I have regarding my health insurance coverage or benefits levels should be directed to my health plan.
5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION.** I understand that Balancing Point Center for Wellness may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and support those who are caring me. I authorize my clinician(s) and Balancing Point administrative staff to contact other health care professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Balancing Point's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.
6. **HIPAA AUTHORIZATION.** I acknowledge I have read and understand the ***HIPAA Patient Privacy Statement.*** In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

_____ _____

Name Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this Document and sign below freely and voluntarily.

_____ _____

Signature of Patient or Legally Responsible Person Date

_____

Printed name of above

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Patient Treatment Consent Form

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," as much as you have experienced when you crack your knuckles. You may feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

As part of the analysis, examination, and treatment, you are consenting to any of the following procedures:

- Spinal Manipulation
- Ranges of Motion Testing
- Muscle Strength Testing
- Ultrasound
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapies
- Radiographic Studies
- EMS
- Basic Neurological Testing
- Acupuncture

THE MATERIAL RISKS INHERENT IN A CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These may include, but are not limited to, fracture, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations. Some types of manipulations 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. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The probability of risks occurring is rare and generally results from an underlying weakness of bone. **Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and is estimated to occur between 1 in 1 million and 1 in 5 million**. The other complications are also described as rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include self-administered, over the counter analgesics and rest, medical care and prescriptions drugs, hospitalizations or surgery. If you choose to use one of the aforementioned treatment options, you should be aware there are risks and benefits of such options and those should be discussed with your primary care giver. Remaining untreated may allow the formation of adhesions and reduction to mobility which may set up a pain reaction. Over time, this process may complicate treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read the above explained and have had my questions answered by my chiropractor.

Patient Name: _____ Date: _____

Signature: _____ Doctor Signature: _____