Great Basin Chiropractic P.C.

A Creating Wellness Center

Mark B. Resetarits, D.C.

Date:_____ PT ID#_____

Name:_____Address:_____

City:_____State:_____ Zip Code_____

Home Phone:_____ Cell#:_____

Birth date:_____ Age:_____ Sex: M F

Email Address:_____

Name of Spouse/Partner:_____

Children names & ages:_____

Business Employer:_____ Work Number:_____

Type of work:_____

Referred to this office by:_____

Emergency contact & relationship:_____ Phone#_____

CURRENT HEALTH CONDITION

What is the reason you are consulting us today?_____

_____

When did this condition begin?_____, How did this condition start?_____

_____

Has this occurred before? Y N

Have you seen other doctors for this condition? Y N, if yes Who?_____

_____

Type of treatment?_____ Results?_____

223 South 700 East · Salt Lake City, UT 84102 · **Phone** (801) 363-8899 · **Fax** (801) 363-1221

www.GreatBasinChiropractic.com

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Is your condition: Job related _____ Auto Accident _____ Fall _____ Other_____

If job related did you report it to your employer? Y N

If an auto accident: Date of Accident:_____ Time of accident:_____ AM PM

Medications you are taking:_____

Do you wear custom orthotics ? Y N Are you interested in being assessed for orthotics if they would help your condition? Y N

PAST HISTORY

Have you had any of the following?: and When?

Major surgeries:_____

Broken bones:_____

Major accidents or falls:_____

When was your last automobile accident?:_____

Hospitalization (other than above):_____

Previous Chiropractic care: Y N Doctors name:_____

Last adjustment:_____

How have you used Chiropractic Care in the past?:

(Circle one) Wellness Pain As needed

How would you rate the stress in your life, Scale from 1 – 10? _____

On a scale from 1 – 10, How important is your health? _____

Who is your primary care physician? _____

Your nervous system controls every function in your body. It communicates with and controls every cell, tissue and organ. How efficient do you think your nervous system? Place a mark on the image below.

Do you have any dietary restrictions? Please circle:

Vegetarian Vegan Gluten Free Dairy Free

Do you eat fast food? Y N If yes, how many times per week? _____

Do you have any of the following medical issues? Please Circle:

High Cholesterol	Hypertension	Thyroid Disease
Auto-Immune Disease	Arthritis	ADHD

If YES are you taking medication for them? Y N

Does your family have a history of any of the following? Please circle:

Heart Disease/Hypertension Coeliac Ds./Gluten Intolerance

Our Mission is to promote vitality through Chiropractic Care, educated lifestyle choices and knowledge. Every choice we make, either moves us toward, or away from health, quality of life and longevity. The following questions pertain to frequently overlooked parameters that have a profound effect on health.

Have you ever had labs or been tested for the following?

Gluten Intolerance: Y N Results:_____

Vitamin D3: Y N Results:_____

Homocysteine: Y N Results:_____

Zinc Levels: Y N Results:_____

Do you take any of the following:

Omega 3's: Y N How much?_____

Probiotics: Y N How much?_____

Multi-Vitamins: Y N How much?_____

Vitamin D3: Y N How much?_____

Patient Signature:_____ Date:_____

Witness Signature_____ Date:_____

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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

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 care 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 if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices 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 request a copy of our privacy notices at any time.

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 us 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 this consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date Date

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Financial Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees for which you are responsible to Great Basin Chiropractic (GBC) for services rendered. Having insurance is not a guarantee of payment to this Clinic. Ultimately, you are responsible for all fees accrued at GBC. You are responsible for paying the deductible, co-pay, and any other balance not paid for by your insurance. Many insurance companies have fixed allowances or percentages based upon your contract with them. These limits are not necessarily in line with the fees charged at GBC. We will, as a courtesy to you, bill your insurance company. Your insurance should pay within 30 days. In the event that your insurance has not paid within 60 days, you must pay the balance due, and be reimbursed by your insurance company, when and if it pays. GBC will extend a 60-day interest free grace period. Any balance not paid after 60 days is subject to a 1.5 percent/month interest fee.

I understand that in the course of care, Dr. Resetarits may make recommendations for my treatment that my insurance company may deem "NOT MEDICALLY NECESSARY." I take full responsibility for those services, and will reimburse Dr. Resetarits in full, should such a situation arise.

BENEFICIARY'S NOTICE

I authorize the release of all records necessary to process my claims (including the claims of any family/household members for whom I bear financial and/or legal responsibility) and that is pertinent to my (and/or our) Chiropractic care. I assign all benefits to which I am entitled, to Dr. Mark B. Resetarits. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

In the event that any outstanding balance is turned over for collection on this account, I agree to pay the outstanding balance, plus reasonable attorney's fees, court costs, interest at 1.5% per month (18% per annum), and a 50% collection agency commission.

In the event that the courts are used to secure payment from an insurance company/companies, or other entity, I agree to pay my outstanding balance at GBC out of any settlement obtained.

MISSED APPOINTMENTS

In addition, I agree to pay GBC a $30.00 fee for all **regular** appointments canceled, missed or broken without 24 hours advance notice. Appointments requiring additional time will be charged at full value for the doctor's time.
_____ (Patient's initials)

Insured's name:_____ Policy Number:_____
Patient's name: _____ Group Number:_____
Insurance Company:_____

Other Insurance: In the name of_____
Date of Birth of the insured:_____
Insurance Company: _____
Policy Number: _____ Group Number:_____

I have read the above, and understand and agree to these terms of financial responsibility.

Patient/ Responsible Party Signature:_____ Date _____
Witness Signature: _____ Date _____

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date:_____

Witness Name:_____ Signature:_____ Date:_____

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