WELCOME TO PEAK PERFORMANCE CHIROPRACTIC

TODD R. STEVENSON, D.C.

APPLICATION FOR TREATMENT

Please Print Legibly

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ □ Male □ Female Name you prefer to be called _____

Contact Phone Number Cell, Home, or Work (circle one) _____ Addt'l Number Cell, Home, or Work (circle one) _____

Marital Status _____ Spouse's Name _____ # Children _____

E-Mail Address _____

(we will never give out your e-mail to a 3rd party. Your e-mail address will *only* be used for the front desk staff or your doctor to contact you)

How were you referred to our office? _____

Employer _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Work Duties (i.e. Desk Work, On Feet, Driving, ...) _____

Is your insurance through your employer? Yes No

Insurance Information **(may be left blank if any of this information is legible on insurance card)**

Primary Insurance _____

Address _____

Phone Number _____ ID # _____ Group # _____

Insured's Name _____ *Insured's Date of Birth* _____

Relation _____ Insured's Employer _____

Secondary Insurance Information _____

Emergency Contact

Name _____ Relation _____

Contact Phone Number Cell, Home, or Work (circle one) _____

Who is your M.D.? _____ Phone Number _____

_____

Minor Authorization *If Patient is under the age of 18,* ***Parental/Guardian Consent is Required*** *for Treatment*

Account Information Person Ultimately Responsible for Account (Parent or Legal Guardian)

Name _____ Relation _____

Address _____ City _____ State _____ Zip _____

Contact Phone Number Cell, Home, or Work (circle one) _____ Signature _____

Parent or Legal Guardian Signature

Reason For Today's Visit

Patient Name:_____ Date:_____

□ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

Are you in Pain □ Yes □ No Rate Pain on Scale of 1 (discomfort) to 10 (intense) _____

Did you injury occur during: □ Work □ Sports/Play □ Auto Accident □ Routine/Home Activity
When did your condition/accident occur? _____ Where did your injury occur? _____
Please explain what happened: _____

_____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and Goes
Where are your major areas of complaint? □ Neck □ Midback □ Low Back □ Other _____
Is your condition interfering with your: □ Work □ Sleep □ Daily Routine? If so, how? _____

_____

Has this or something similar happened in the past? □ Yes □ No If yes, please explain _____

_____

Have you been treated by a Medical Physician for this condition? □ Yes □ No
If yes, where? _____
Have you been treated by a Chiropractor before? □ Yes □ No If yes, please indicate Dr. or
Clinic's name and approximate time since last visit _____

Health History

Are you taking any medications? □ Yes □ No If yes, indicate type and reason

_____

_____

_____

Please list any surgeries with dates and/or and other serious medical conditions:

_____

_____

Do you exercise? □ Yes □ No Approximate hours per week ____ Do you smoke? □ Yes □ No If yes, how much? _____
Do you take supplements or vitamins? □ Yes □ No Are you dieting? □ Yes □ No
Are you wearing: □ Shoe Lifts □ Arch Supports □ Inner Soles
For Women: Are you pregnant? □ Yes □ No Are you taking birth control? □ Yes □ No Are you nursing? □ Yes □ No

Please mark any other of the following diseases, health problems, or medical procedures you have or have had in the past:

□ Heart Attack/Stroke	□ Heart Surgery/Pace Maker	□ Heart Murmur	□ Congenital Heart Defect
□ Alcohol/Drug Abuse	□ Hepatitis	□ HIV+/AIDS/ARC	□ Venereal Disease
□ Shingles	□ Glaucoma	□ Anemia	□ Diabetes
□ Cancer	□ High/Low Blood Pressure	□ Chemotherapy	□ Tuburculosis
□ Frequent Neck Pain	□ Severe/Frequent Headaches	□ Fainting/Seizures/Epilepsy	□ Difficulty Breathing
□ Lower Back Problems	□ Artificial Bones/Joints/Limbs	□ Arthritis	□ Degenerative Joint Disease
□ Kidney Problems	□ Ulcers/Colitis	□ Other _____	□ Other _____

Any further health information you would like to discuss with your doctor? _____

_____

For Office Use Only

_____

_____

_____

Peak Performance Chiropractic
275 Hill Street, Suite 101 Reno, NV 89501

YOU MAY KEEP THIS FORM FOR YOUR RECORDS OR REQUEST A COPY AT ANY TIME

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health is very important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on 09-15-2009 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted and applicable by law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we can make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you

Payment: We may use or disclose your health information to obtain payment for services we provided to you

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professional, evaluating practitioner and provided performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. Peak Performance Chiropractic provides quality healthcare in a semi-open environment. During your treatment, incidental details about your care may be disclosed to others in the open environment in which we provide care. The doctors, office staff, and massage therapists are committed to protecting your health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient's Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or worth payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Peak Performance Chiropractic

275 Hill Street, Suite 101 Reno, NV 89501 (775) 786-PEAK

To Our Patients:

Please contact our office if you have any questions about a bill or explanation of benefits that you may receive from your insurance company. When dealing with insurance companies, it can be difficult to interpret the information they return to you.

Financial Policy

Cash Patients: Payment is due in full at the time of service. You may request a super bill or receipt with information regarding your payment, diagnosis, and treatment at any time, including for past visits.

Insurance Patients:

Please provide a copy of your insurance card and identification for completion of your file. Our front desk staff will attempt to identify your coverage and deductible information, but ultimately, you are responsible for knowing if you have chiropractic coverage and whether or not your deductible has been met.

Nevada State Insurance Laws require health insurance companies to pay medical claims within 60 days of receipt of the claim. Our office submits claims generally within 2 days of services being rendered. We highly recommend that you keep in touch with your insurance company to ensure that timely and proper payments of your medical claims are made. Your insurance coverage is a contract between the employer/patient and your insurance company, and regardless of insurance coverage, the patient is ultimately responsible for the billed charges.

Preferred Provider Organizations (PPO's): Your co-pay is due at the time of service. As a courtesy, we bill your insurance for you; however the Patient/Responsible Party is also responsible for 100% of any services they may have that are not authorized or limited by your particular insurance plan.

HMO/EPO Patients: Your co-pay is due at time of service. If your insurance requires authorization for office visits, it is the patient's responsibility to contact their Primary Care Physician (PCP) for proper referral/authorization. If we do not have an authorization at time of visit your appointment can be rescheduled, or you can become a cash patient.

Medicare Patients: We do not bill Medicare directly. You are responsible for the cash rate of your visit, but can request a paper statement to send directly to Medicare.

Personal Injury Patients:

We accept patients with motor vehicle claims, including (but not limited to) those represented by an attorney, third party claims, and med-pay. Please be aware, that you, the patient, are ultimately responsible for your bill if payment is not made by an insurance company or an attorney. You are also responsible for payment in full if the at-fault insurance company pays you directly at the final settlement of your claim. You will be sent to collections if payment is not made in 30 days after settlement.

I have read, understand, and agree to the PEAK PERFORMANCE CHIROPRACTIC Financial Policy.

_____ _____ _____

Patient Name (Printed) Patient Signature Date

Peak Performance Chiropractic

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▶ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.

▶ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

▶ Peak Performance Chiropractic provides quality healthcare in a semi-open environment. During your treatment, incidental details about your care may be disclosed to others in the semi-open environment in which we provide care. The doctors, staff, and massage therapists are committed to protecting your health information.

▶ I have received a copy of the Notice of Health Information Privacy Practices. I have been given the opportunity to keep this form and have had any questions I may have answered for me by the front desk staff.

▶ I understand the forms I have completed and answered correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

_____ Signature

_____ Printed Name

_____ Date