

# CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status:  M  D  S  W Children, Ages \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_

What is your major complaint?

\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

Do any positions make it feel worse? \_\_\_\_\_

Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Is this condition interfering with your:  Work  Sleep  Daily Routine Other \_\_\_\_\_

Other doctors or therapist who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_

Medications, dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_

Have you been in an auto accident or had any other personal injury?  Y  N Describe

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**REVIEW OF SYSTEMS** Check only the ones you now have or have had in the past.

<b>GENERAL</b>	<b>NOW</b>	<b>PAST</b>	<b>THROAT</b>	<b>NOW</b>	<b>PAST</b>	<b>GASTROINTESTINAL</b>	<b>NOW</b>	<b>PAST</b>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>			<b>NECK</b>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<b>BREASTS</b>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD</b>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<b>LUNGS</b>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS</b>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEART</b>			Urine Color _____		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
<b>NOSE</b>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD</b>			Age at First Period _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
<b>MOUTH</b>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam _____		
						Last Mammogram _____		
						Last Prostate Exam _____		

NAME \_\_\_\_\_

<b>NEUROLOGIC</b>	<b>NOW</b>	<b>PAST</b>
Seizures	<input type="checkbox"/> N <input type="checkbox"/> P	
Vertigo	<input type="checkbox"/> N <input type="checkbox"/> P	
Dizziness	<input type="checkbox"/> N <input type="checkbox"/> P	
Hand Trembling	<input type="checkbox"/> N <input type="checkbox"/> P	
Loss of Sensation	<input type="checkbox"/> N <input type="checkbox"/> P	
Incoordination	<input type="checkbox"/> N <input type="checkbox"/> P	
Loss of Facial	<input type="checkbox"/> N <input type="checkbox"/> P	
Weak Grip	<input type="checkbox"/> N <input type="checkbox"/> P	
Paralysis	<input type="checkbox"/> N <input type="checkbox"/> P	
Difficulty Speech	<input type="checkbox"/> N <input type="checkbox"/> P	
Tingling	<input type="checkbox"/> N <input type="checkbox"/> P	
Loss of Memory	<input type="checkbox"/> N <input type="checkbox"/> P	
Numbness	<input type="checkbox"/> N <input type="checkbox"/> P	

**ENDOCRINE**

Weight Loss	<input type="checkbox"/> N <input type="checkbox"/> P
Weight Gain	<input type="checkbox"/> N <input type="checkbox"/> P
Extremely Thin	<input type="checkbox"/> N <input type="checkbox"/> P
Heat Intolerance	<input type="checkbox"/> N <input type="checkbox"/> P
Cold Intolerance	<input type="checkbox"/> N <input type="checkbox"/> P
Hair Changes	<input type="checkbox"/> N <input type="checkbox"/> P
Breast Changes	<input type="checkbox"/> N <input type="checkbox"/> P

**IMMUNIZATION/VACCINATION**

DPT	Y <input type="checkbox"/>
Mumps	Y <input type="checkbox"/>
Smallpox	Y <input type="checkbox"/>
Typhoid	Y <input type="checkbox"/>
Tetanus	Y <input type="checkbox"/>
Measles	Y <input type="checkbox"/>
Pneumococcal	Y <input type="checkbox"/>
Influenza	Y <input type="checkbox"/>
Polio	Y <input type="checkbox"/>
MMR	Y <input type="checkbox"/>

**BLOOD TYPE**

A + <input type="checkbox"/>	A - <input type="checkbox"/>
B + <input type="checkbox"/>	B - <input type="checkbox"/>
AB + <input type="checkbox"/>	AB - <input type="checkbox"/>
O + <input type="checkbox"/>	O - <input type="checkbox"/>
Other _____	

**BLOOD TRANSFUSIONS**

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

<b>PSYCHIATRIC</b>	<b>NOW</b>	<b>PAST</b>
Hyperventilation	<input type="checkbox"/> N <input type="checkbox"/> P	
Insecurity	<input type="checkbox"/> N <input type="checkbox"/> P	
Depression	<input type="checkbox"/> N <input type="checkbox"/> P	
Troubled Sleep	<input type="checkbox"/> N <input type="checkbox"/> P	
Irritable	<input type="checkbox"/> N <input type="checkbox"/> P	
Undecidedness	<input type="checkbox"/> N <input type="checkbox"/> P	
Timid	<input type="checkbox"/> N <input type="checkbox"/> P	
Hallucinations	<input type="checkbox"/> N <input type="checkbox"/> P	
Loss of Memory	<input type="checkbox"/> N <input type="checkbox"/> P	
Alcoholism	<input type="checkbox"/> N <input type="checkbox"/> P	
Drug Addiction	<input type="checkbox"/> N <input type="checkbox"/> P	
Drug Dependent	<input type="checkbox"/> N <input type="checkbox"/> P	
Suicidal Thoughts	<input type="checkbox"/> N <input type="checkbox"/> P	
Extreme Worry	<input type="checkbox"/> N <input type="checkbox"/> P	
Sexual Problems	<input type="checkbox"/> N <input type="checkbox"/> P	

<b>MUSCULOSKELETAL</b>	<b>NOW</b>	<b>PAST</b>
Muscle Pain	<input type="checkbox"/> N <input type="checkbox"/> P	
Muscle Weakness	<input type="checkbox"/> N <input type="checkbox"/> P	
Muscle Cramps	<input type="checkbox"/> N <input type="checkbox"/> P	
Muscle Twitching	<input type="checkbox"/> N <input type="checkbox"/> P	
Joint Stiffness	<input type="checkbox"/> N <input type="checkbox"/> P	
Joint Pain	<input type="checkbox"/> N <input type="checkbox"/> P	

**PAST MEDICAL HISTORY. Check only the ones you have had in the past .**

Hay Fever	Y <input type="checkbox"/>	Parasites	Y <input type="checkbox"/>
Mumps	Y <input type="checkbox"/>	Epilepsy	Y <input type="checkbox"/>
Rheumatic Fever	Y <input type="checkbox"/>	Paralysis	Y <input type="checkbox"/>
Allergies	Y <input type="checkbox"/>	Polio	Y <input type="checkbox"/>
Angina	Y <input type="checkbox"/>	Mental Illness	Y <input type="checkbox"/>
Cancer	Y <input type="checkbox"/>	Alcoholism	Y <input type="checkbox"/>
Tumor	Y <input type="checkbox"/>	Depression	Y <input type="checkbox"/>
Blood Disease	Y <input type="checkbox"/>	Nervous Breakdown	Y <input type="checkbox"/>
Leukemia	Y <input type="checkbox"/>	Migraine	Y <input type="checkbox"/>
Heart Trouble	Y <input type="checkbox"/>	Gout	Y <input type="checkbox"/>
Varicose Veins	Y <input type="checkbox"/>	Hemorrhoids	Y <input type="checkbox"/>
Phlebitis	Y <input type="checkbox"/>	Prostate Problems	Y <input type="checkbox"/>
Hypertension	Y <input type="checkbox"/>	Sexual Problems	Y <input type="checkbox"/>
Stroke	Y <input type="checkbox"/>	Gonorrhea	Y <input type="checkbox"/>
Ulcers	Y <input type="checkbox"/>	Syphilis	Y <input type="checkbox"/>
Jaundice	Y <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/>
Skin Trouble	Y <input type="checkbox"/>	Bladder Trouble	Y <input type="checkbox"/>
Gallstones	Y <input type="checkbox"/>	Kidney Stones	Y <input type="checkbox"/>
Liver Trouble	Y <input type="checkbox"/>	Kidney Infections	Y <input type="checkbox"/>
Hepatitis	Y <input type="checkbox"/>	Dysentery	Y <input type="checkbox"/>

Date of Last Chest X-Ray \_\_\_\_\_  Normal  Abnormal

Last TB Skin Test \_\_\_\_\_  Normal  Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

**SOCIAL HISTORY** Check the boxes and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_ Height \_\_\_\_\_

Mental Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Physical Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Exercise  Heavy  Moderate  Light Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Smoking  Current  Previous Packs/Day \_\_\_\_\_ No. of years \_\_\_\_\_

Alcohol Beer/Week \_\_\_\_\_ Liquor/Week \_\_\_\_\_ Wine/Week \_\_\_\_\_ No. of Years \_\_\_\_\_

Caffeine (Coffee, Tea, Cola) Cups/Day \_\_\_\_\_ No. of Years \_\_\_\_\_

Aspirin No./Day \_\_\_\_\_ No. of Years \_\_\_\_\_ Others \_\_\_\_\_

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.** Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles . . . . Stabbing ////

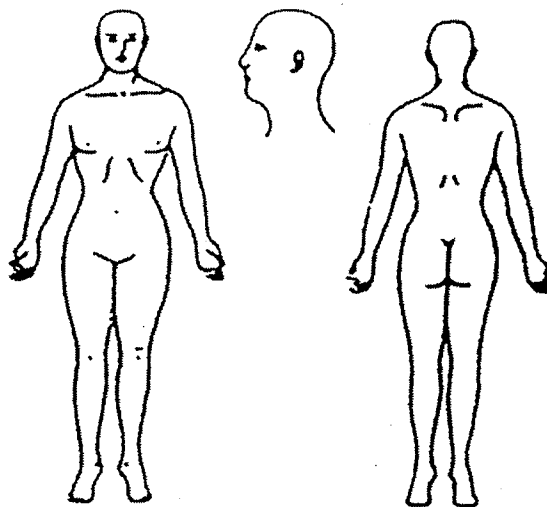
**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

None \_\_\_\_\_ Most Severe \_\_\_\_\_

How bad have they been in the past?

None \_\_\_\_\_ Most Severe \_\_\_\_\_



# Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, naturopathic doctors, and /or licensed physical therapists, or massage therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes, rarely, but not limited to fractures, disc injuries, stroke, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

**Female Patients:** By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

**Date of last menstrual period** \_\_\_\_\_.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or authority if not signed  
By patient.

\_\_\_\_\_  
Witness

# **NOTICE OF INFORMATION PRACTICES**

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

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name \_\_\_\_\_ Phone \_\_\_\_\_

The effective date of this Notice of Information Practices is \_\_\_\_\_.

Thank you.

**GRAHAM REHABILITATION & WELLNESS CENTER INC. P.S.**

**PATIENT AUTHORIZATION  
FOR THE USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

1. I, \_\_\_\_\_, hereby authorize Graham Rehabilitation & Wellness Center Inc. P.S. (the "Practice") to use and /or disclose to my major medical insurance, auto insurance, and worker's compensation insurance the following specific protected health information: Health history, examination findings, radiographs findings, prescribed treatment recommendations, and daily treatment records.
2. I understand that this authorization is valid until a written termination of this authorization is received.
3. I understand that the purpose or use of the disclosure I am granting is for payment of services provided to me by Graham Rehabilitation & Wellness Center Inc. P.S.
4. I expressly acknowledge that this authorization is voluntary.
5. the following is/are other criteria or limitations that I make regarding this authorization:

\_\_\_\_\_  
\_\_\_\_\_

6. I understand that the office will receive financial or in-kind compensation for providing the health information described above to auto insurance carriers and or worker's compensation carriers.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time, and this will not have any effect on disclosures occurring prior to the execution of any revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that I my healthcare and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, and that I will get a copy of this form after I sign it, if I ask for it.
11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. this authorization is valid as of \_\_\_\_\_, the date I have signed below:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Legal Representative  
(e.g. Attorney-In-Fact, Guardian, Parent of minor)

\_\_\_\_\_  
Witness



The following is an explanation of our clinic policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue – re-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

**Payments:**

At Graham Rehabilitation & Wellness Center Inc. P.S. (GRWC) your healthcare needs are our primary concern. We do not want finances to get in the way of you getting the care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

- If you do not have insurance, **ALL** payments are expected at the time of service. Prepayments are also allowed.
- If you have insurance, **ALL COPAYS** are due at time of service.
- There will be a 1.5% finance charge added to all balances after 60 days.
- There will be a \$25.00 charge on all returned checks.
- If you need any additional documentation of payments other than a receipt please feel free to ask the front desk.

**Insurance Coverage:**

Our fees are considered usual, customary and reasonable by most companies, and there fore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. GRWC will bill your primary insurance for services rendered, any **secondary** insurance billing is the sole responsibility of the patient.

As a courtesy to you our office staff will verify your primary insurance. The quotation of benefits given to us by the insurance company is just that, and does not guarantee payment for treatment in our center. It is ultimately the patient's responsibility to know the details of the policy and the patient agrees to pay for any services not reimbursed by the insurance carrier.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you are treating in our office and have a Personal Injury or 3<sup>rd</sup> Party claim that necessitates a lien, GRWC will do all the administrative tasks involved however the cost of the lien (\$40.00) will be the patient's responsibility upon treatment.

**X-rays:**

We will release your X-rays to another doctor only after you sign a release/transfer form and your account has been paid in full, unless you have been referred for a consultation. We need 48 hours notice to enable us to mail X-rays in time for your appointment.

**Appointments/Treatments:**

Graham Rehabilitation & Wellness Center Inc. P.S. is a very busy clinic and when an appointment is scheduled for you, we reserve that time for you only. There will not be a fee for rescheduling or canceling an adjustment. However for all Rehabilitation and Massage Therapy appointments there is a \$15 to \$35 fee of our clinic is not given a 24 business hour notice.

**Release and Wellness:**

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

*I have read and understand Graham Rehabilitation & Wellness Center Inc. P.S. office policies and I will honor them.*

Patient's Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_