1 Personal Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

Email: _____

Date of Birth: _____ Social Security #: _____

Gender (circle): Male Female

Occupation: _____ Employer: _____

Marital Status (circle): Single Married Widowed Separated Divorced

Spouse's Name: _____ Spouse's Phone Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

2 Health Insurance Information

Person Responsible for Payment: _____ Relationship: _____

Are you insured? (circle) Yes No Insurance Company Name: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Member ID #: _____ Group #: _____

Is the patient covered by additional insurance? (circle) Yes No Insurance Company Name: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Member ID #: _____ Group #: _____

3 Accident Information

Is this condition due to an accident? (circle): Yes No

Type of Accident (circle): Auto Work Other: _____

To whom have you reported it? (circle): Auto Insurance Employer Police Other: _____

Date of Accident: _____ Attorney (if Applicable): _____

Name of Auto Insurance: _____ Claim #: _____

4 PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Peterson Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Peterson Chiropractic will be credited upon receipt, however, I clearly understand and agree that any services rendered to me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable.

Patient Signature: _____ Date: _____

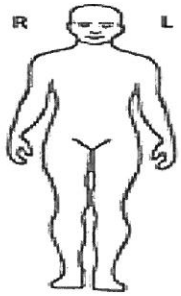
Guardian Signature: _____ Date: _____

5 Patient Intake Form

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◯ Auto Accident ◯ Worker's Comp ◯ Other

2. Indicate on the drawings to the right where you have pain/symptoms:



3. How often do you experience your symptoms:

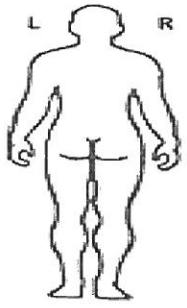
◯ Constantly (76-100% of the time) ◯ Occasionally (26-50% of the time)
◯ Frequently (51-75% of the time) ◯ Intermittently (1-25% of the time)

4. How would you describe your pain?

◯ Sharp ◯ Dull ◯ Diffuse ◯ Electric-like w/ motion
◯ Achy ◯ Burning ◯ Shooting ◯ Shooting w/ motion
◯ Numb ◯ Tingly ◯ Stiff ◯ Sharp w/ motion

5. How are your symptoms changing with time?

◯ Getting Worse ◯ Staying the same ◯ Getting Better



6. From 0-10, 10 being the worst, how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

◯ Not at all ◯ A little ◯ Moderately ◯ Quite a bit ◯ Extremely

8. How much has the problem interfered with your social activities?

◯ Not at all ◯ A little ◯ Moderately ◯ Quite a bit ◯ Extremely

9. Who else have you seen for your problem?

◯ Chiropractor ◯ Neurologist ◯ Primary Care Physician
◯ ER physician ◯ Orthopedist ◯ No one
◯ Massage Therapist ◯ Physical Therapist ◯ Other: _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? ◯ Yes ◯ Sometimes ◯ No

13. What aggravates your problem? (makes it worse) _____

14. What alleviates your problem? (makes it better) _____

15. What concerns you the most about your problem; what does it prevent you from doing? _____

16. What is your: Height: _____ Weight: _____ Date of Birth: _____

17. Occupation: _____ Have you missed work?: _____ How much?: _____

18. How would you describe your overall health?

◯ Excellent ◯ Very Good ◯ Good ◯ Poor

19. What type of exercise do you do?

◯ Strenuous ◯ Moderate ◯ Light ◯ None

20. Indicate if you have any immediate family members with any of the following:

◯ Rheumatoid Arthritis ◯ Diabetes ◯ Lupus
◯ Heart Problems ◯ Cancer ◯ ALS (Lou Gehrig's Disease)

21. List all medications you are currently taking including over-the-counter medication: _____

_____

22. List all surgical procedures you have had: _____

23. What activities do you do outside of work?: _____

24. Have you ever been hospitalized? _____ If yes, why? _____

25. Have you had significant past trauma? _____

26. Have you previously seen a chiropractor? _____ If yes, why? _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ Date: _____

Peterson Chiropractic
1878 W. 3600 S.
West Valley City, UT 84119

Consent for Use and 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.
- ~ We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
- ~ We may need to use your health information within our practice for quality control or other operational purposes.
- ~ We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you for your referrals, acknowledge your referral on an in office referral board, send you a welcome to the office informational letter, invite you to participate in patient appreciation days, send you an office newsletter, or send promotional information.

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.
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 for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

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 upon 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 received 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 your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Print Name Authorized Provider Representative

_____ _____

Signature Date

Aside for those legally mandated, (for example, other doctors and/or insurance companies) you must **specify precisely who you permit our office to discuss your information with. THIS IS TO PROTECT YOUR PRIVACY.

( ) I hereby authorize the following individual(s) to discuss my Personal Health Information as indicated below

( ) I hereby authorize the following individual(s) to request copies of my medical records (anything we have on file).

( ) My Spouse: _____

( ) Name or Names: _____ Relationship: _____

Signature of Patient or Guardian: _____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION
("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and /or other legal entities ("payers'), which may elect or be obliged to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, Peterson Chiropractic (or "office") such sums as may be owing to Peterson Chiropractic for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to Peterson Chiropractic with respect to my charges, applicable to all payers, however, I understand that nothing in the Agreement shall be construed as an election by Peterson Chiropractic to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, loss wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Peterson Chiropractic, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Peterson Chiropractic the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office. I further direct each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to Peterson Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Peterson Chiropractic to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Peterson Chiropractic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Peterson Chiropractic for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Peterson Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees up to 50%.

This agreement shall not be modified or revoked without the mutual written consent of Peterson Chiropractic and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Peterson Chiropractic and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print): _____

Patient Signature: _____ Date _____/_____/_____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian's Signature: _____ Date _____/_____/_____

Peterson CHIROPRACTIC
Dr. Bradley R. Peterson
Quality spinal care with a personal touch

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in future treat me while employed by, working or associated with serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-name procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental & Relationship: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____