Desert Shadows Chiropractic and Wellness
Christopher C. Campo. D.C.
4010 E. Bell Rd. #103 Phoenix, AZ 85032
Phone:602-595-0015

Patient Information

Name:_____

How were you referred to our office?_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Social Security #_____ Date of Birth_____ Date of Injury/Onset_____

Sex: M / F Marital Status: S M W D Spouse's Name_____ Number of Children_____

Height:_____Feet_____Inches Weight_____Pounds Dominant Hand: R / L (Please Circle One)

Email_____ May we email you on occasion regarding occasional promotions at our office? Circle one: Y / N –we never distribute personal info to outside parties for marketing purposes.

Employer:_____ Occupation:_____

Primary Physician:_____ Phone:_____

Primary Insured:_____ Relationship:_____

SS# of Primary Insured_____ Primary Date of Birth_____

Insurance Company:_____ Policy#_____ Group#_____

Employer:_____ Emergency Contact_____ Phone_____

FINANCIAL AGREEMENT

If any signer is entitled to benefits under any insurance policy, the benefits are hereby assigned to the patients treating Chiropractor for application on the patient's bill; however, **IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL (including any deductible).** It is intended by this provision to allow the patients treating Chiropractor to bill and receive payments directly from the above insurance company without giving up our right to bill and collect from the undersigned all unpaid services rendered by the patients treating Chiropractor. **Our office will not enter a dispute with your insurance company over any claims.** Please be advised that verification of insurance coverage is not a guarantee of benefit payments. **In the event your account is submitted to collections, you will be responsible for all associated charges and fees.**

The undersigned will be responsible for a $35.00 returned check fee.

MISSED APPOINTMENT POLICY/CANCELLATION POLICY

Your appointment times are carefully scheduled to deliver efficient care to all of our patients. Missed appointments may deny other patients from receiving care during that time slot; **therefore, we have instituted a $25.00 "missed appointment" fee schedule conflict within 24 hours of your next appointment.**

By signing below, you affirm that you accept and understand these policies.

_____ _____

Patient's Signature **Date**

_____ _____

Guardian Signature **Date**

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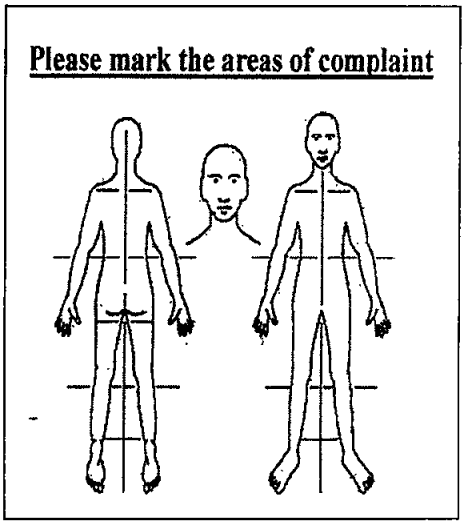
Patient Health Questionnaire



Patient Name_____ _____

Please describe your current problem_____

_____

Is your current problem the result of: Auto Accident? ___Yes ____No

Work accident? ___Yes ___No Slip & Fall? ___Yes ___No

How did your problem begin_____

Date Problem began_____

Other doctors seen for this condition_____

List other treatments or tests you've had for this condition_____

Have you been treated for any other health condition by a physician in the last year? __Yes __No If yes, please explain:

_____

How often are your symptoms present? __Constantly __Frequently __Occasionally __Intermittently

Describe your current pain/symptoms: __Sharp/Stabbing __Burning __Throbbing __Shooting __Tingling __Gripping
__Dull __Numbness __Soreness __Aches __Weakness __Other_____

Since it began, is your problem: __Improving __Getting Worse __No Change

What makes the problem worse? __Nothing __Lying Down __Standing __Walking __Sitting __Movement
__Exercise __Inactivity/Rest __Other_____

What makes the problem better? __Nothing __Lying down __Standing __Walking __Sitting __Movement
__Exercise __Inactivity/Rest __Other_____

Can you perform your daily home activities? __Yes __Only with help __Not at all

Do you exercise? __Yes, often __Yes, occasionally __Not at all

Describe your job requirements: __Mainly Sitting __Light Labor __Heavy Labor __Other_____

Can you perform your daily work activites: __Yes, all activities __Only some __Not at all

Describe your stress level: __None to mild __Moderate __High

Please list all allergies including allergies to medications:_____

List all medications you are presently taking (including vitamins & supplements)_____

_____

List any surgeries, fractures, serious illness or hospitalizations _____

Patient's Signature_____ Date_____

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Patient Questionnaire

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

GENERAL SYMPTOMS

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Gain/Loss of weight
- Numbness/pain in arms, hands legs
- Allergy
- Wheezing
- Neuralgia-neuritis
- Depression

E.E.N.T.

- Failing vision
- Near sightedness
- Far sightedness
- Crossed eyes
- Eye pain
- Deafness
- Earache
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Tinnitus
- Asthma
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

SKIN

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hive or allergy

RESPIRATORY

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing

CARDIOVASCULAR

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart attack
- Hardening of the arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Aneurysm

MUSCLE & JOINT

- Stiff neck
- Backache
- Swollen joints
- Painful tailbone
- Foot trouble
- Pain in shoulders
- Hernia
- Spinal curvature
- Faulty posture
- Arthritis

GENITOURINARY

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Kidney stones
- Bed wetting
- Inability to control urine
- Prostate trouble

GASTROINTESTINAL

- Poor appetite
- Difficult digestion
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Constipation
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

FOR WOMEN ONLY

- Painful menstruation
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal symptoms
- Pregnancy

HAVE YOU HAD OR CURRENLTY HAVE ANY OF THE FOLLOWING:

- Appendicitis
- Scarlet fever
- Diphtheria
- Typhoid fever
- Pneumonia
- Rheumatic fever
- High blood pressure
- Polio
- Malaria
- Tuberculosis
- Whooping cough
- Anemia
- Measles
- Mumps
- Small pox
- Chicken pox
- Liver disease
- Diabetes
- Cancer
- Heart disease
- Goiter
- Influenza
- Pleurisy
- Alcoholism
- Venereal infection
- Epilepsy
- Mental disorder
- Eczema
- Drug dependency
- Emphysema
- Asthma
- H.I.V.
- Aids

DO YOU DRINK? (CUPS PER DAY)

- **COFFEE**_____
- **TEA**_____
- **CAFFEINATED SOFT DRINKS**_____

TOBACCO(PACKS PER DAY)_____

Comments:_____

_____

Patient's Signature_____ Date_____

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AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. I authorize this health care facility to release all information related to the care I receive to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes. In addition, I authorize the use of my signature on all insurance submissions from this facility and any outside billing organization.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or based in whole, or in part upon charges for your services. I direct that said insurance companies, mail payment directly to your office address and payment be issued in the name of your treating Chiropractic Physician Christopher C. Campo, D.C.

3. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of the settlement of any case that I am seeking a settlement from.

4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action in either my name or your name as you see fit. However, it is understood that I remain fully responsible for any amount due on my account regardless of the circumstances.

5. I agree to make a full payment to Christopher C. Campo, D.C Chiropractic Physician at the time of service is rendered unless other arrangements are made in advance of treatment.

6. If any amount is billed to me on a monthly statement, I agree to pay the full amount due by the first day of the following month. I also understand that if I fail to make full payment, a 15% interest charge will be added to my total account balance and is due immediately.

7. In the event that payment is not made and further action is necessary to enforce payment, I agree to pay any and all collection costs, court costs, and reasonable attorney fees required to collect the amount due on my account.

8. In the event treatment is rendered due to an accident (either an automobile accident or an accident by any other cause) and I do not retain an attorney, a lien will be filed with the Maricopa County Recorder's Office against any and all insurance companies that may be responsible for payment and against me personally. I agree that I am responsible for the fees charged for the filing and release of said claim.

9. I agree that a copy of this agreement shall be considered as valid as the original.

10. In the event the patient is a minor, I agree as the parent or legal guardian of the patient to all of the above and agree that I am responsible for all of the above as same as if the treatment was for myself.

11. This Authorization and Assignment cannot be rescinded without written consent from Dr. Christopher C. Campo D.C. of Deserts Shadows Chiropractic

12.

Date_____ Patient's Signature_____

Date_____ Witness Signature_____

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ACKNOWLEDGEMENT AND AGREEMENT PROTOCOL FOR RECORDS AND PRIVACY PRESENTATION

I _____, patient of Christopher C. Campo,
(Print name of patient)

D.C., hereby acknowledges that I have received, read and understand the doctor's protocol for the privacy and preservation of patient records.
I agree to inform Christopher C. Campo, D.C and/or their front office staff of any address changes and acknowledge that all requests for records by either my representatives, or me must be in writing.

I agree that Christopher C. Campo, D.C. may comply with all statutory notification requirements to me by regular mail to my address.

_____ Date_____
(Signature of Patient)

_____
(Patient's Address)

Witness:_____Date_____

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PATIENT CONSENT TO TREATMENT

Please read prior to signing. Please ask any questions if there is anything that is unclear.

The nature of the chiropractic adjustment.
A primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We may use our 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" and you may feel a sense of movement.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to procedures that we may recommend and/or discuss with you.

The material risks are inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, separations, and burns. Some types of manipulation of the neck have been associated with injuries to neck arteries leading to or contributing to serious complications including stroke. It is not uncommon to feel some stiffness and soreness following the first few days of treatment. We will make a reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.
Fractures from chiropractic treatment are rare and generally result from some underlying weakness of the bone which we screen for during the taking of your history, exam and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally 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 prescription drugs such as anti-inflammatory, muscle relaxant and pain-killers
-Hospitalization and/or Surgery

The risks and dangers attendant to remaining untreated.
Remaining untreated-may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.
I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the patients treating Chiropractor/front office staff and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended.
Having been informed of the risks, I here give my consent to that treatment.

_____ _____
Patient's Name **Doctor's Name**

_____ _____
Patient's Signature **Guardian Signature if Patient is a minor**

Date_____

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Desert Shadows Chiropractic & Wellness

I _____ have discussed with the management of Desert Shadows Chiropractic & Wellness the possibility that my insurance company may apply a **co-insurance** **co-pay** **deductible** to my chiropractic visits. I acknowledge by signing below that these charges are my financial responsibility and payable to Desert Shadows Chiropractic & Wellness

I also understand that if I choose to stop treatment, I am still responsible for payment of the **co-insurance/co-pay/deductible** amount for my chiropractic visits that I have completed.

I assign to Dr. Christopher C. Campo, DC/Desert Shadows Chiropractic and Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that, I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

_____ _____

Patient's Signature Date