Name: ___________________________Date ________ Provider Signature: _________________

Apple Wellness Center
Winchester Spine & Injury

3038 Valley Avenue Winchester VA 22601
Phone: 540-545-7891 Fax: 540-545-7893

Patient Information

Full Name: _________________________________ Social Security Number: ___________________

Date of Birth: _______________________ Age: ______________ Sex (circle one): Male Female

Address: _________________________ City: ___________________ State: _______ Zip: ________

Home Phone: ______________________________ Cell Phone: ______________________________

Email: ______________________________________ Occupation: ____________________________

Employer: __________________________________ Work Phone: ___________________________

Status (circle one): Married Single Partnered Divorced Widowed Separated Minor

Primary Care Provider: ___________________________ City, State: __________________________

How did you hear about us? ____

Emergency Contact

Name: _______________________________________ Relationship: _________________________

Home Phone: _________________________________ Cell Phone: ___________________________

Insurance Information

Primary Subscriber: ____________________________ Relation to Patient: _____________________

Insurance Company: ___________________________ ID Number: ___________________________

Secondary Insurance: __________________________ ID Number: ___________________________

Assignment and Release

I understand and agree that, regardless of the insurance or medical benefits I have, I am ultimately responsible to pay Apple Wellness Center the balance due on my account for any professional services rendered and for any supplies, or tests provided. I hereby authorize payment of any health insurance or medical plan benefits directly to Apple Wellness Center for medical services rendered and for any supplies, or tests provided. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in my records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue other legal remedies necessary in connection with the same. I hereby assign directly to Apple Wellness Center all current and prior rights, if any, to payment and benefit and all legal and other health plan rights that I have or my child, spouse, or dependent may have under my/our applicable health plan(s) or health insurance policy. This assignment includes, but is not limited to, a designation that Apple Wellness Center personnel can act on my/ our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Apple Wellness Center as a result of services rendered by Apple Wellness Center and authority to pursue any and all remedies to which I/we may be entitled to, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing and a photocopy is to be considered as valid and enforceable as the original.

Financial Policy

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time of service rendered, unless prior arrangements have been made. For your convenience, we accept all major credit card, cash, and checks. I agree that should this account be referred to an agency or attorney for collection, I will be responsible for all collection costs, attorney, and court fees and costs.

I have read and understand all of the above statements and have agreed to these statements.

Print Name: _______________________ Signature: _______________________ Date: _________

Guardian Name: ____________________ Signature: _______________________ Date: _________

Name: ____________________________ Date ________ Provider Signature: ________________

Medical History

Gynecologic History (Females Only)

Are you currently pregnant? Yes/No Pregnancies #: _________ Deliveries #: _________
Natural or C-Section? _________________________ Dates: ______________________________
Menstrual - Onset: _______________ Duration: _____________ Last Cycle: ________________
Are they regular? Yes/No Are they painful? Yes/No

General History (Check all that apply to you):

__AIDS/HIV	__Alcoholism	__Allergy Shots	__Anemia
__Appendicitis	__Arthritis	__Asthma	__Anorexia
__Blood Disorders	__Blood Transfusion	__Breast Lump	__Bronchitis
__Bulimia	__Cancer	__Cataracts	__Chemical Dependency
__Chest Pain	__Chicken Pox	__Cholera	__Constipation
__Diabetes	__Eating Disorders	__Emphysema	__Epilepsy
__Fractures	__Gallbladder	__Glaucoma	__Goiter
__Gonorrhea	__Gout	__Heart Attack	__Heart Disease
__Hepatitis	__Hernia	__Herniated Disc	__Herpes
__High Blood Pressure	__High Cholesterol	__Hormone Replace	__Hypertension
__Jaundice	__Kidney Disease	__Liver Disease	__Malaria
__Measles	__Migraines	__Miscarriage	__Mononucleosis
__Multiple Sclerosis	__Mumps	__Nervous Habits	__Osteoporosis
__Pacemaker	__Parkinson's	__Pinched Nerve	__Pleurisy
__Pneumonia	__Polio	__Prostate Problems	__Prosthesis
__Psychiatric Care	__Rheumatoid Arth.	__Rheumatic Fever	__Scarlet Fever
__STD	__Stroke	__Suicide Attempt	__Swelling Feet
__Thyroid Problems	__Tonsillitis	__Tuberculosis	__Tumors/Growths
__Typhoid Fever	__Ulcers	__Vaginal Infection	__Whooping Cough
__ Vertigo	__ Other: _________	__ Other: _________	__ Other: _________

Medications (Please list all medications taken regularly and the dosage of each, including Birth Control):____
____

Medical and General Allergies: ____
____

Surgical History (Please list all past surgeries with dates and any surgical devices, if any): ________
____

Family History (Please list any significant or hereditary conditions):___________________________
____

Social Habits (check all that apply):

__Alcohol	Drinks per week: _________
__Smoking	Packs per day: ___________
__Coffee/Caffeine	Cups per day: ___________
__High Stress	Reason: _______________

Activity Level:

__Inactive (No regular physical activity, including work)
__Lightly Active (No organized physical activity during leisure time)
__Moderately Active (Occasionally involved in actives such as golf, tennis, jog, swim, cycle)
__Heavily Active (Consistent lifting, stair climbing, regular sports at least 3 times per week)
__Vigorously Active (Extensive activity for 60 minutes, 4 times per week or more)

Name: ____________________ Date ________ Provider Signature: ______________

Height: ______________ Weight: ______________ Ideal Weight: ______________

History of Present Illness

Headache/Migraine?	Yes/No	How Often: ______________
Neck Pain?	Yes/No	How Often: ______________
Shoulder Pain? L/R	Yes/No	How Often: ______________
Elbow Pain? L/R	Yes/No	How Often: ______________
Mid-Back Pain?	Yes/No	How Often: ______________
Lower Back Pain?	Yes/No	How Often: ______________
Hip Pain? L/R	Yes/No	How Often: ______________
Knee Pain? L/R	Yes/No	How Often: ______________
Ankle Pain? L/R	Yes/No	How Often: ______________

Main Complaint:

1. When did the symptoms start? ______________
2. How did they begin? ______________
3. Have you had it before? Yes / No If yes, describe: ______________
4. Exactly how does the symptom feel? ______________
5. Rate the severity from 1 - 10 (1=Mild, 10=Severe): ______________
6. Timing of symptoms:
   How many times a day: ________ How long it lasts: ________
   How many times a week: ________ How long it lasts: ________
   How many times a month: ________ How long it lasts: ________
7. Does it radiate? Yes / No If yes, from where to where? ______________
8. What makes the symptom feel better or relieves it? ______________
9. What makes it feel worse or aggravates it? ______________
10. Is there a family history of this? Yes / No If yes, Who? ______________
11. Are you taking prescription medications for this? Yes / No If yes, What? ______________
12. Have you had previous treatment for this? Yes / No If yes, who did you see and what was the outcome? ______________
13. What have you tried on your own and what were the results? (Examples: Heat or Ice, OTC Meds, Stretching, Chiropractic, Physical Therapy etc.) ______________

Name: ______________________Date _______ Provider Signature: ______________

Additional Complaint:

1. When did the symptoms start? ________________________________
2. How did they begin? ________________________________
3. Have you had it before? Yes / No If yes, describe: ________________________________
   ____
4. Exactly how does the symptom feel? ________________________________
   ____
5. Rate the severity from 1 - 10 (1=Mild, 10=Severe): ________________________________
6. Timing of symptoms:
   How many times a day: __________ How long it lasts: ______________
   How many times a week: __________ How long it lasts: ______________
   How many times a month: __________ How long it lasts: ______________
7. Does it radiate? Yes / No If yes, from where to where? ________________________________
   ____
8. What makes the symptom feel better or relieves it? ________________________________
   ____
9. What makes it feel worse or aggravates it? ________________________________
   ____
10. Is there a family history of this? Yes / No If yes, Who? ________________________________
    ____
11. Are you taking prescription medications for this? Yes / No If yes, What? ______________
    ____
12. Have you had previous treatment for this? Yes / No If yes, who did you see and what was the outcome? ________________________________
13. What have you tried on your own and what were the results? (Examples: Heat or Ice, OTC Meds, Stretching, Chiropractic, Physical Therapy etc.) ________________________________
    ____

*Please request additional form if you have additional complaints.

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 an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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:

Parent or Guardian: ____________________ Signature: ____________________ Date:

Witness Name: ____________________ Signature: ____________________ Date:

Name: ___________________________Date ________ Provider Signature: ________________

Notice of HIPAA Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

A Notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of your health information is available to you upon request. We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations.

TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. PAYMENT means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review. HEALTH CARE OPERATIONS include managing your Electronic Medical Record to facilitate diagnostic medical consultations with participating physicians, as well as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may contact you to provide information about our services or other health-related services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete. You have a right to receive a list of certain instances when we have used or disclosed your medical information. If you ask for this information from us more than once every twelve months, we may charge you a fee.

I have read and understand the above statement and agree to these privacy practices.

Patient Name: ____ Date: ________________

Patient Signature: ____

Notice of Privacy

I hereby authorize Apple Wellness Center and or any of its doctors, chiropractors, and staff to share and update my medical information from this office with the following person(s), family member(s), etc.

Person or Family Member Authorized: ____

Patient Name: ____ Date: ________________

Patient Signature: ____

Authorization for Disclosure of Health Information

Patient Name ____________________

Date of Birth ____________________

Date of Request ______________________

I hereby authorize the use or disclosure of the above named individual's health as described below.

The following individual or organization is authorized to make the disclosure

___

The type of information to be disclosed is as follows:

Problem List	Medication List	Allergy List	Immunization Record
Progress Note	History & Physical	Consultation	Entire Record

Imaging Report Dated ____________________________

Other ____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome AIDS),or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the Apple Medical Clinic, LLC in Winchester Virginia also doing business as Apple Wellness Center and or Winchester Spine & Injury in Winchester Virginia. The purpose of the disclosure of information is for Apple Medical Clinic, LLC DBA Apple Wellness Center and or Winchester Spine & Injury to more fully evaluate my history and past medical findings as well as prior treatments that have been rendered to me or recommended.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition ____, If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosed information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions, I may contact

Health Information Manager / Privacy Officer
Phone 540-545-7891
Fax 540-545-7893

Patient Name ______________________________

Patient Signature ______________________________

Signature of Legal Representative if applicable ____________________________

Witness Signature ______________________________

Date ________________