Patient Name: _____Date: _____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____ Sex: M F Marital Status: M S D W

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Occupation _____Employer _____

How have you heard of us: Website Google Social Media Word of Mouth
Who can we thank for referring you: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____
Reason for stopping care: _____

Emergency Contact and Phone Number: _____
Spouse Name: _____ Spouse Employer and Position/Title: _____
Kids Name(s) and Ages:
_____
_____

1. **Past Health History:**
   - **A. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

   - **B. Previous Injury or Trauma: _____**
     Have you ever broken any bones? Which? _____
   - **C. Allergies: _____**

2. **Family Health History:**
   Do you have a family history of? (Please indicate all that apply)
   □ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
   □ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
   □ Other _____ □ None of the above

   A. Deaths in immediate family:

Cause of parents' or siblings' death	Age at death
_____	_____
_____	_____
_____	_____
_____	_____

3. **Social and Occupational History:**
   - **A. <u>Job description</u>: _____**
   - **B. <u>Work schedule</u>: _____**
   - **C. <u>Recreational activities</u>: _____**
   - **D. <u>Lifestyle</u>**
     Hobbies: _____

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Patient Name: _____Date: _____

Level of Exercise: _____
Alcohol Use: _____
Tobacco Use: _____
Drug Use: _____
Diet: _____

4. Medications:

Medication:	Reason for taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

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Patient Name: _____Date: _____

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Ryan Wilk, D.C./Ryno Family Chiropractic for services performed.

Patient or Guardian Signature: _____
Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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Patient Name: _____Date: _____

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

NEW PATIENT HISTORY FORM

Symptom 1: _____ Left Right Bilateral (Circle one)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin? (Circle one): Suddenly Gradually
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (Circle all that apply):
  - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, laying down, reading, working, exercising, laying on side in bed, other (Please describe): _____
- What makes the symptom better? (Circle all that apply):
  - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, nothing, chiropractic adjustments, massage, other (Please describe): _____
- Describe the quality of the symptom (Circle all that apply):
  - Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, shooting, stinging, piercing, stiff, other (Please describe): _____
- Does the symptom radiate to another part of your body (Circle one): Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one):
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No ○ Yes

  O Anti-inflammatory meds O Pain medication O Muscle relaxers O Trigger point injections
  O Cortisone injections O Surgery O Massage O Physical Therapy O Chiropractic
  O Other _____

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Patient Name: _____Date: _____

Symptom 2: _____ Left Right Bilateral (Circle one)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin? (Circle one): Suddenly Gradually
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (Circle all that apply):
  - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, laying down, reading, working, exercising, laying on side in bed, other (Please describe): _____
- What makes the symptom better? (Circle all that apply):
  - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, nothing, chiropractic adjustments, massage, other (Please describe): _____
- Describe the quality of the symptom (Circle all that apply):
  - Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, shooting, stinging, piercing, stiff, other (Please describe): _____
- Does the symptom radiate to another part of your body (Circle one): Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one):
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No ○ Yes

  O Anti-inflammatory meds O Pain medication O Muscle relaxers O Trigger point injections
  O Cortisone injections O Surgery O Massage O Physical Therapy O Chiropractic
  O Other _____

Symptom 3: _____ Left Right Bilateral (Circle one)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin? (Circle one): Suddenly Gradually
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (Circle all that apply):
  - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, laying down, reading, working, exercising, laying on side in bed, other (Please describe): _____

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Patient Name: _____Date: _____

- What makes the symptom better? (Circle all that apply):
  - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, nothing, chiropractic adjustments, massage, other (Please describe): _____
- Describe the quality of the symptom (Circle all that apply):
  - Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, shooting, stinging, piercing, stiff, other (Please describe): _____
- Does the symptom radiate to another part of your body (Circle one): Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one):
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No ○ Yes

  O Anti-inflammatory meds O Pain medication O Muscle relaxers O Trigger point injections
  O Cortisone injections O Surgery O Massage O Physical Therapy O Chiropractic
  O Other _____

Symptom 4: _____ Left Right Bilateral (Circle one)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin? (Circle one): Suddenly Gradually
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (Circle all that apply):
  - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, laying down, reading, working, exercising, laying on side in bed, other (Please describe): _____
- What makes the symptom better? (Circle all that apply):
  - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, nothing, chiropractic adjustments, massage, other (Please describe): _____
- Describe the quality of the symptom (Circle all that apply):
  - Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, shooting, stinging, piercing, stiff, other (Please describe): _____
- Does the symptom radiate to another part of your body (Circle one): Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one):
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No ○ Yes

  O Anti-inflammatory meds O Pain medication O Muscle relaxers O Trigger point injections
  O Cortisone injections O Surgery O Massage O Physical Therapy O Chiropractic
  O Other _____

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Patient Name: _____Date: _____

Symptom 5: _____ Left Right Bilateral (Circle one)

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin? (Circle one): Suddenly Gradually
- When did the symptom begin? _____
  - How did the symptom begin? _____
- What makes the symptom worse? (Circle all that apply):
  - Nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, laying down, reading, working, exercising, laying on side in bed, other (Please describe): _____
- What makes the symptom better? (Circle all that apply):
  - Nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, nothing, chiropractic adjustments, massage, other (Please describe): _____
- Describe the quality of the symptom (Circle all that apply):
  - Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, shooting, stinging, piercing, stiff, other (Please describe): _____
- Does the symptom radiate to another part of your body (Circle one): Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one):
  - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
  - No ○ Yes

  O Anti-inflammatory meds O Pain medication O Muscle relaxers O Trigger point injections
  O Cortisone injections O Surgery O Massage O Physical Therapy O Chiropractic
  O Other _____

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Patient Name: _____Date: _____

Ryno Family Chiropractic
10200 W. Happy Valley Rd. Ste. 135, Peoria, AZ, 85383
623.432.2543

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature: _____ Date: _____

Name: _____

Patient Name: _____Date: _____

PATIENT OPTIONS ACCESS PROGRAM
FREE PATIENT ENROLLMENT AGREEMENT

As a patient, you are a participant in a Discount Managed Care Organization provided by Patient Options. There is NO FEE for patients to participate, and it is provided free to the public for those who are uninsured or otherwise underinsured. This Agreement and its terms and conditions, is between you and Patient Options. This Agreement is effective as of the date you sign below and are electronically enrolled at www.PatientOptions.org by your Provider and shall continue for a period of exactly one year (12 months) from the date of signature below. You will automatically be reenrolled for successive one year (12 month) periods unless request in writing.

There are no fees, dues, charges or other consideration required for participation.

DISCLOSURES:

· The Program provides discounts to you from contracted healthcare providers for services rendered;

· The Program participant is obligated to pay for all healthcare services directly to provider but will receive a discount from healthcare providers who have contracted with Patient Options;

·This is NOT insurance or a qualified policy under the Affordable Care Act or any state regulated program. Patient agrees this program and the discounts offered by contracted Providers are not available in instances where a third party insurance company is responsible for charges.

· Patient absolves provider of wrongdoing in the event the patient chooses to bill insurance for discounted services rendered under this Agreement;

· The name and address of the Discount Managed Care Organization is: Patient Options; 9435 Waterstone Blvd., Suite #140, Cincinnati, Ohio 45249. (866) 275-5633

This Disclosure and its Benefit descriptions represent the entire agreement between you and Patient Options and supersedes all other prior representations, statements, or written agreements between you and Patient Options.

I have read and agree to the terms and conditions set forth above:

Name: _____ Signature: _____

Address: _____ Date: _____

_____

_____

**Additional Household participants may be enrolled free of charge under the same terms of this Agreement. To activate, please write their names below:

1. _____ 2. _____

3._____ 4. _____

5._____ 6. _____

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