KAIZEN
PROGRESSIVE HEALTH

Last Name: _____ **First Name**: _____ Date: _____/_____/_____
Email: _____ Home Phone:_____ Cell Phone: _____

SS#: _____ DOB: _____/_____/_____ ☐ Male ☐ Female

Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Address _____City _____ State_____ Zip_____
Employer Name: _____
Name of the insured party: _____ Relationship to patient:_____
Insured party date of birth:_____ Address (if different from patient)_____
Person to contact in case of an emergency: _____Phone: _____

"In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence."

_____ x_____ _____
Parent or GUARDIAN Name **Parent or GUARDIAN Signature** **Date**

Whom may we thank for referring you? ⭕ Google ⭕ Yelp ⭕ Facebook ⭕ Event ⭕ Other _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Kaizen Progressive Health (Kaizen Medical Group), Dr. Stephen Hruby, Dr. Robin MacDougall, Joel Olmstead,** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your 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 any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(PATIENT signature)

X_____(SEAL) _____
(signature of GUARDIAN if applicable) (please print patient name)

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Health History

Chief Complaint: (*Describe*)

_____

History of Present Illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration:** _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors** _____
(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History: (Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....NO YES	Anemia.....NO YES	Back Trouble.....NO YES	
Hepatitis.....NO YES	Mumps.....NO YES	Bladder Infection.....NO YES	
High Blood Pressure.....NO YES	Ulcer.....NO YES	Chicken Pox.....NO YES	
Epilepsy..... NO YES	Low Blood Pressure.....NO YES	Kidney Disease.....NO YES	Whooping Cough.....NO YES
Migraine Headaches..... NO YES	Hemorrhoids.....NO YES	Thyroid Disease.....NO YES	
Scarlet Fever.....NO YES	Tuberculosis..... .NO YES		
Asthma.....NO YES	Small pox.....NO YES	Cancer.....NO YES	
Hives of Eczema.....NO YES	Pneumonia.....NO YES	Polio.....NO YES	
AIDS & HIV.....NO YES	Rheumatic Fever.....NO YES	Glaucoma.....NO YES	
Infectious Mono.....NO YES	Arthritis.....NO YES	Hernia.....NO YES	
Bronchitis..... NO YES	Venereal Disease.....NO YES	Mitral Valve Prolepses..... NO YES	
Stroke.....NO YES	Blood or Plasma Transfusion...NO YES	Any Other Disease.....NO YES	

(Please List): _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (INCLUDE non-prescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion? NO / YES if yes what type: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure At home or at work to (mark if yes)**: *Fumes:*____ *Dust:*____ *Solvents:*____ *Airborne Particles:*____ *Noise:*____**

***(CLINICIAN) SIGNATURE*: _____ DATE REVIEWED: _____**

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Family Medical History:

	Age	Disease	*If Deceased, Cause Of Death*
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the *last 1-2 months*:

1=Never; **2**=Rarely; **3**=Occasionally; **4**=Frequently; **5**=Constantly

Eyes/Ears/Nose/Throat/Respiratory Muscular/Skeletal

Asthma 1 2 3 4 5
Stuffy Nose 1 2 3 4 5
Hay Fever 1 2 3 4 5
Sore throat 1 2 3 4 5
Chronic Cough 1 2 3 4 5
Chest Congestion 1 2 3 4 5
Frequent Sneezing 1 2 3 4 5
Itchy/Watery Eyes 1 2 3 4 5
Drainage 1 2 3 4 5
Earache/Ear Infection 1 2 3 4 5
Itching 1 2 3 4 5
Hoarseness 1 2 3 4 5
Shortness of Breath 1 2 3 4 5
Wheezing 1 2 3 4 5

Muscle Aches 1 2 3 4 5
Fibromyalgia 1 2 3 4 5
Arthritis 1 2 3 4 5
Joint Pain 1 2 3 4 5
Low Back Pain 1 2 3 4 5
Neck Pain 1 2 3 4 5
Wrist/Hand Pain 1 2 3 4 5
Elbow Pain 1 2 3 4 5
Shoulder Pain 1 2 3 4 5
Hip Pain 1 2 3 4 5
Knee Pain 1 2 3 4 5
Ankle/Foot Pain 1 2 3 4 5
Pain b/t shoulder blades 1 2 3 4 5

Neurological

Headaches 1 2 3 4 5
Migraines 1 2 3 4 5
Dizziness 1 2 3 4 5
Numbness 1 2 3 4 5
Tingling 1 2 3 4 5
Pins/needles 1 2 3 4 5 in hands or feet

General

Fatigue 1 2 3 4 5
Malaise 1 2 3 4 5
Weakness/tiredness 1 2 3 4 5
Lightheadedness 1 2 3 4 5
Irritability 1 2 3 4 5
Constipation 1 2 3 4 5
Diarrhea 1 2 3 4 5
Feeling foggy 1 2 3 4 5
Forgetfulness 1 2 3 4 5

DRUG RELATED ALLERGIES (Please list):

DRUG: _____ REACTION: _____
DRUG: _____ REACTION: _____
DRUG: _____ REACTION: _____
DRUG: _____ REACTION: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X_____ _____

Signature of the Patient, Parent or Guardian **Date**

***(CLINICIAN) SIGNATURE*: _____ DATE REVIEWED: _____**

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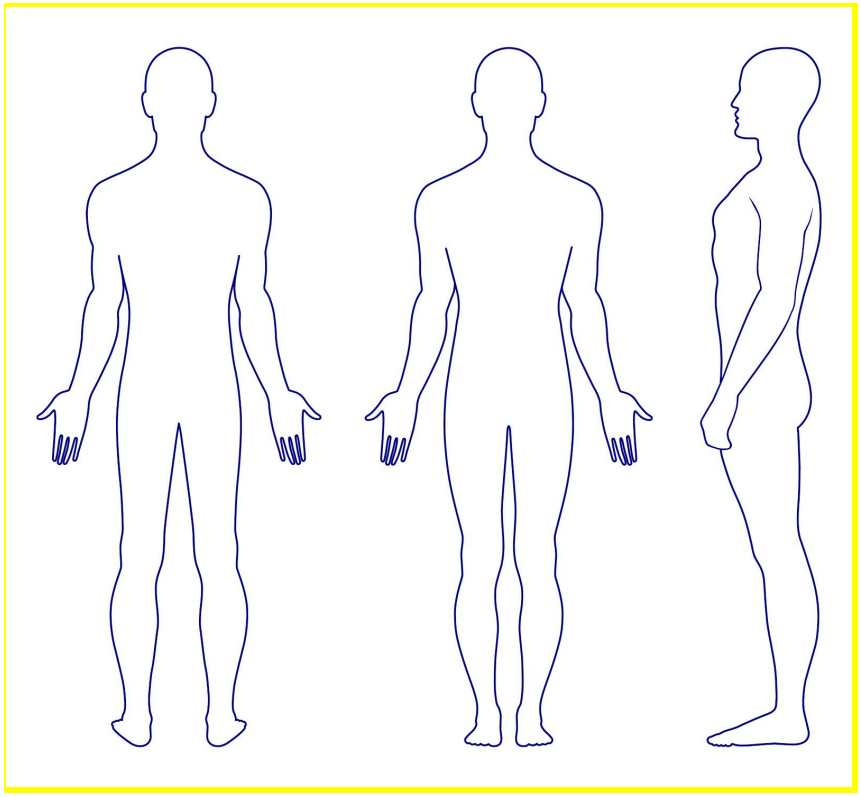
Please circle areas of pain and injury. Please be prepared to describe the type and quality of pain.



FRONT **BACK** **SIDE**

X_____ _____

Signature of the Patient, Parent or Guardian **Date**

_____OFFICE USE BELOW_____

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic, Dr. Stephen Hruby, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. Dr. Hruby has additionally explained the risks associated with my refusal of treatment.

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-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ **Date** _____

Witness Signature _____ **Date**_____

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FINANCIAL POLICY

Patient Agreement:
I,_____, have read, understand and agree to the terms of the Financial Policy provided to me.

Patient/Responsible Party:
Signature: _____ Date: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS (HIPAA)

Patient Agreement:
I,_____, have read, understand and agree to the terms of the Consent provided to me.
Patient/Responsible Party:
Signature: _____ Date: _____

PRIVACY POLICY

I have read the Privacy Notice and understand my right contained in the notice. By signing this notice, I provide Kaizen and its practitioners with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.
Patient Agreement:
I,_____, have read, understand and agree to the terms of the Consent provided to me.
Patient/Responsible Party:
Signature: _____ Date: _____