Welcome to the Center for Alternative Medicine

Welcome to our practice! Please take a few minutes to fill out the following health history, so that Dr. Jenkins can provide you with the best health care possible. Our receptionist will want to make a copy of your insurance card and a photo ID (required by law). If you have any questions are problems when filling out this form, please don't hesitate to ask.

First name_____ Last name_____ Preferred name_____

Birthdate_____ Gender_____ Social Security_____ Marital status_____

Address_____ City, State_____ Zip_____

Occupation_____ Employer name_____

CONTACT INFORMATION

Emergency contact_____ Emergency phone_____ Home phone_____

Mobile phone_____ Work phone_____ Email_____

May we contact you by text messaging? ☐ yes ☐ no

INSURANCE (if a copy of this card is provided to the receptionist, this section may be left blank)

Insurance name_____ Subscriber ID_____

Insurance address_____ Insurance phone #_____

SECONDARY INSURANCE (if a copy of this card is provided to the receptionist, this section may be left blank)

Insurance name_____ Subscriber ID_____

Insurance address_____ Insurance phone #_____

HEALTH HISTORY

What is your reason for today's visit?_____

Have you ever had, or do you currently have, any of the following health problems?(check all that apply)

AIDS/HIV		Alcohol/drug addiction		Allergy (hay fever)		Allergy (food)	
Anemia		Anxiety		Arthritis		Asthma	
Blood clots		Broken vertebrae		Cancer		Cataracts	
Circulation problems		COPD/emphysema		Cysts		Depression	
Diabetes		Dysmenorrhia		Easy bleeding		Eating disorder	
Eczema		Epilepsy		Glaucoma		Gluten sensitivity	
Gout		Hearing loss		Heart attack/disease		Heart murmur	
Hepatitis		High blood pressure		Infertility		Kidney/bladder problem	
PMS		Reflux/GERD		STD		Sickle cell anemia	
Stroke		Thyroid problem		Tuberculosis		Ulcers	
Vision problem							

Please check any tests you have had within the past year and their results:

EXAM	N/A	Normal	Abnormal	Date/comments
Breast exam				
Cardiac echo				
ECG				
Gynecological exam				
Mammogram				
Physical exam				
Prostate exam				
Rectal exam				
Sigmoid/colonoscopy				
Retinal exam				
Flu vaccination				
Pneumonia vaccination				
LDL				
Hemoglobin				
PSA				

FAMILY HISTORY

Relative Health problems Age

FATHER_____

MOTHER_____

SIBLINGS_____

SIBLINGS_____

SIBLINGS_____

CHILDREN_____

CHILDREN_____

CHILDREN_____

LIFESTYLE

Recreational drugs use (including tobacco and alcohol):

CURRENT QUIT (Date)

_____ _____

_____ _____

_____ _____

Exercise duration_____ Exercise type_____ Frequency_____

Diet: ☐ Mixed food diet ☐ Vegetarian ☐ Vegan ☐ High Protein ☐ Other

Food allergies_____

GENDER-RELATED DISORDERS

Men: ☐ Benign prostate hypertrophy ☐ Prostate cancer ☐ Decreased sex drive ☐ Infertility

Women: ☐ Menstrual irregularities ☐ Endometriosis ☐ Infertility ☐ Decreased sex drive ☐ Fibrocystic breast

☐ Fibroids/ovarian cysts ☐ PMS ☐ Breast cancer ☐ Pelvic inflammatory disease ☐Vaginal infections

PRESENT ILLNESS

Please check off **any symptoms you are currently experiencing:**

Unexplained weight change		Fever		Chills		Fatigue	
Night sweats		Insomnia		Appetite change		Headache	
Visual change		Hearing loss		Earache		Ringing in ears	
Nosebleeds		Sinus problems		Bleeding gums		Sore throat	
Shortness of breath		Irregular heart beat		Swelling of ankles		Nausea	
Vomiting		Stomach pain		Bloating		Diarrhea	
Gout		Hearing loss		Heart attack/disease		Heart murmur	
Constipation		Burning when urinating		Blood in urine		Frequent urination	
incontinence		Muscle pain		Joint pain		Numbness	
Weakness		Seizures		Fainting			

List any medications or nutritional supplements/herbs you are currently taking:

Medication	Supplement/Herb
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the above information is correct and complete.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. Avery Jenkins or the Center for Alternative Medicine, PC and its employees.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for the Chiropractor is also posted in the waiting room at Center for Alternative Medicine, PC. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative’s Authority

Consent for Treatment

Dr. Jenkins may perform or order any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat your health concerns:

General Diagnostic Procedures: Including, but not limited to, physical exams, diagnostic imaging (X-rays, ultrasound, etc.), venipuncture, and other specimen collection for diagnostic lab work.

Lifestyle Counseling: Promotion of wellness using recommendations for exercise, sleep, stress management and balancing of work and social activities.

Botanical Remedies: Use of plant substances in oral and topical forms and homeopathic remedies (dilute quantities of naturally occurring plant, mineral and animal substances) in oral and topical forms.

Dietary Advice and Therapeutic Nutrition: Use of foods, diet plans and/or nutritional supplements.

Soft Tissue and Chiropractic Manipulation: use of massage, neuromuscular techniques, and chiropractic manipulation of the extremities and spine.

Acupuncture: Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Alternatively, electrical devices or lasers may be used to stimulate the acupuncture points.

Potential Risks: The risks of complications due to chiropractic treatment have been described as rare, about the same as the risk from taking a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at 1:1,000,000 to 1:10,000,000, and may be reduced even further by screening procedures.

The risks of acupuncture treatment are similarly rare. Serious side effects have been found in less than 1:10,000 treatments.

Adverse reactions to herbs or other supplements include, but are not limited to, allergic reaction, headache or nausea.

Other risks include, but aren't limited to, pain, discomfort, blistering, discolorations, infection, burns, fainting or tissue injury from needle insertions, topical procedures, heat or frictional therapies; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential Benefits: Including, but not limited to, restoration to health and normal to improved functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention and management of disease.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I hereby authorize Avery L. Jenkins, D.C. as well as any other physicians and staff of the Center for Alternative Medicine, PC to perform or order the above procedures and therapies as necessary to facilitate my diagnosis and treatment. I understand that I may ask questions regarding my individual treatment before signing this form and that I am free to withdraw my constne and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by anyone at the Center for Alternative Medicine PC.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

Financial Policies

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy *as it applies to your particular situation.*

PATIENTS WITHOUT INSURANCE: We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing.

GROUP OR INDIVIDUAL INSURANCE: ***When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment.*** Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. ***Regardless of insurance coverage or legal representation, you are responsible for payment of your bill.*** We will accept letters of protection ***only*** from attorneys that we have pre-approved.

MEDICARE: We do not accept assignment from Medicare. We will bill Medicare for your treatment here, but Medicare will send the reimbursement to you, not us. **Please be aware that Medicare pays for manual manipulation of the spine only, and your treatment in this office will likely require non-covered services.** You are responsible for payment of all services at the time of visit.

PLEASE NOTE: INSURANCE COVERAGE VARIES SIGNIFICANTLY AMONG PLANS. WE CANNOT PREDICT YOUR COVERAGE. YOU ARE RESPONSIBLE FOR ALL CO-PAYMENTS, DEDUCTIBLES AND KNOWN NON-COVERED SERVICES AT THE TIME OF VISIT.

INSURANCE AUTHORIZATION

I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Jenkins and my insurance company. I request that the Center for Alternative Medicine, PC, prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Avery Jenkins, that fees will be due and payable immediately.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority