# MOON CHIROPRACTIC CENTER

1751 N Stockton Hill Rd, Ste B
Kingman, AZ 86401
(928) 753-1120
moonchiropractic@hotmail.com

## ABOUT THE PATIENT

Name _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell _____

E-mail _____

Birthdate _____ Age _____ Gender ☐ Male ☐ Female

Employer _____ Occupation _____

Work Address _____ Work Phone # _____

Marital Status ☐ Married ☐ Single ☐ Other Number of children _____

Social Security Number _____ Driver's License Number _____

How did you hear about us? _____

## ABOUT THE SPOUSE OR PARENT

Name _____

Employer _____ Occupation _____

Work Phone _____ Cell Phone _____

## Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Auto Insurance
☐ Medicare ☐ Personal Health Insurance

## ABOUT MY INSURANCE

Ins. Co. Name _____ Policy Number _____

Name of Insured Person _____ Insured's SS# _____

Relation _____ Date of Birth _____

Employer _____

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I agree that, should my account go to collections, I will incur all costs, including but not limited to collection agency fees and lawyer fees. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____ _____ _____
Patient's Signature Date Guardian or Spouse's Signature Date

# Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

**1. When did your symptoms start:** _____ **Describe your symptoms and how they began:**

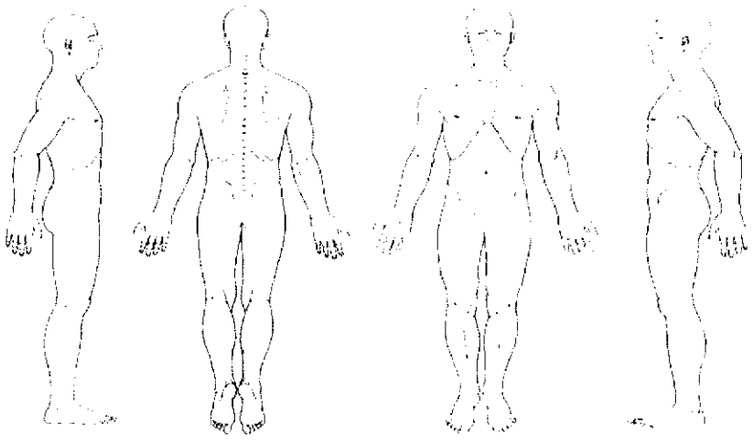
_____

_____

**2. How often do you experience your symptoms?**

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

**Indicate where you have pain or other symptoms**



**3. What describes the nature of your symptoms?**

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

**4. How are your symptoms changing?**

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

**5. How bad are your symptoms at their:**

| | None | | | | | | | | | | Unbearable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **a. worst:** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
| **b. best:** | ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |

**6. How do your symptoms affect your ability to perform daily activities?**

| ⓪ | ① | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |
|---|---|---|---|---|---|---|---|---|---|---|
| *No complaints* | | *Mild, forgotten with activity* | | *Moderate, interferes with activity* | | *Limiting, prevents full activity* | | *Intense, preoccupied with seeking relief* | | *Severe, no activity possible* |

**7. What activities make your symptoms worse:** _____

**8. What activities make your symptoms better:** _____

**9. Who have you seen for your symptoms?**

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

*a. When and what treatment?* _____

*b. What tests have you had for your symptoms and when were they performed?*

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

**10. Have you had similar symptoms in the past?** ☐ Yes ☐ No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

**11. What is your occupation?**

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

*a. If you are not retired, a homemaker, or a student, what is your current work status?*

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

**12. What do you hope to get from your visit/treatment** *(select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

**Patient Signature** _____ **Date** _____

# Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

**What type of regular exercise do you perform?** ☐None ☐Light ☐Moderate ☐Strenuous

**What is your height and weight?** Height ☐☐ (Feet ☐ Inches) Weight ☐☐☐ lbs.

***For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.***

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Upper Back Pain |
| ☐ | ☐ | Mid Back Pain |
| ☐ | ☐ | Low Back Pain |
| ☐ | ☐ | Shoulder Pain |
| ☐ | ☐ | Elbow/Upper Arm Pain |
| ☐ | ☐ | Wrist Pain |
| ☐ | ☐ | Hand Pain |
| ☐ | ☐ | Hip/Upper Leg Pain |
| ☐ | ☐ | Knee/Lower Leg Pain |
| ☐ | ☐ | Ankle/Foot Pain |
| ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Joint Swelling/Stiffness |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | General Fatigue |
| ☐ | ☐ | Muscular Incoordination |
| ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Dizziness |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Heart Attack |
| ☐ | ☐ | Chest Pains |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Angina |
| ☐ | ☐ | Kidney Stones |
| ☐ | ☐ | Kidney Disorders |
| ☐ | ☐ | Bladder Infection |
| ☐ | ☐ | Painful Urination |
| ☐ | ☐ | Loss of Bladder Control |
| ☐ | ☐ | Prostate Problems |
| ☐ | ☐ | Abnormal Weight Gain/Loss |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Ulcer |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | Liver/Gall Bladder Disorder |
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Tumor |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Chronic Sinusitis |

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Smoking/Use Tobacco Products |
| ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Allergies |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | HIV/AIDS |

***Females Only***

| | | |
|---|---|---|
| ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Pregnancy |
| ☐ | ☐ | |

***Other Health Problems/Issues***

| | |
|---|---|
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |

***Indicate if an immediate family member has had any of the following:***

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐_____

***List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:***

_____

_____

***List all the surgical procedures you have had and times you have been hospitalized:***

_____

_____

***Patient Signature*** _____ ***Date*** _____

***Doctor's Additional Comments***

_____

_____

_____

***Doctors Signature*** _____ ***Date*** _____

# Moon Chiropractic Center
# Professional Fee Statement

| | |
|---|---|
| Consultation and Comprehensive Orthopedic / Neurological Exam | $50.00 - $125.00 |
| Routine X-Ray Series (4 Frames) | $100.00 |
| X-Ray Series (2 Views) | $70.00 |
| Basic Office Visit (Adjustment) | $30.00 - $60.00 |
| Routine Pre-Adjustment Brief Exam | $25.00 |
| Extended Office Visit | $40.00 - $80.00 |
| Neuromuscular Re-education | $30.00 |
| House Calls, After Hours or Emergency | $40.00 - $100.00 |
| Manual Traction | $30.00 |

Our experience has shown that it is wise to have an understanding with out patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic care at our office and you may choose the plan that you prefer. This information will enable us to better service you and help to avoid misunderstandings in the future. Our main concern is your health and well-being. We will do our best to help you.

**IMPORTANT: All patients with or without insurance, are responsible for full payment of the first visit (unless other arrangements have been made in advance).**

Today's payment will be made by: CASH __ CHECK ___ CREDIT CARD__

**Insurance**: Please let the front desk know if you have insurance, have been in some type of accident, or if you have been hurt on the job. This will enable them to give you any and all information necessary for us to serve you completely and accurately.

**Agreement**: My signature below signifies my agreement to payment in full on a cash basis if I have no insurance, or if I have not provided Dr. Scott A. Moon with all necessary documents and information by the time of my second visit. I agree that, should my account go to collections, I will incur all costs, including but not limited to collection agency fees and lawyer fees.

*I have read and agree to the above fee statement.*

Patient _____ Date _____

Witness _____ Date _____

*Moon Chiropractic Center*
*1751 Stockton Hill Rd. Ste. B*
*Kingman, Arizona 86401*

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement**

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign _____

Communications barriers prohibited obtaining the acknowledgement_____

An emergency situation prevented us from obtaining acknowledgement_____

Other_____

Moon Chiropractic Center, PLLC
1751 Stockton Hill Road Suite B
Kingman, Arizona 86401

# NOTICE OF PRIVACY PRACTICES

Effective Date: February 1, 2005

This notice describes how personal health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We respect confidentially and only release personal health information about you in accordance with the state and federal law. This notice describes our policies related to the use of the records of your care generated by Moon Chiropractic Center, PLLC.

PRIVACY CONTACT: If you have any questions about this policy or your rights contact the Privacy Coordinator at 928-753-1120

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond MCC. This includes for

TREATMENT: With your permission we may use or disclose personal information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside MCC that we are consulting with or referring you to.

PAYMENT: Information will be used to obtain payment for treatment and services provided. This will include contacting your health insurance company for prior authorization of planned treatment or for billing purposes.

HEALTH CARE OPERATIONS: We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Information disclosed without your consent. Under state and federal law, information about you may be disclosed without your consent in the following circumstances:

EMERGENCIES: Sufficient information may be shared to address the immediate emergency you are facing.

FOLLOW UP APPOINTMENTS/CARE: We will be contacting you to remind you of future appointments or information about treatment alternatives or other health related benefits and services that may be of interest to you.

AS REQUIRED BY LAW: This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse, neglect including child abuse, elder abuse, or institutional abuse.

CORONERS, FUNERAL DIRECTORS: We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purpose of carrying out their duties.

GOVERNMENTAL REQUIREMENTS: We may disclose personal health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse event or product defects. We are also required to share information, if requested, with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

CRIMINAL ACTIVITY OR DAMAGE TO OTHERS: If a crime is committed on our premises or against our personnel we may share information with law enforcement officials to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT REQUESTS

You have the following rights under federal law.

COPY OF RECORD: You may request to inspect the personal health record MCC has generated about you. We may charge you a reasonable fee for copying and mailing your record.

RELEASE OF RECORD: You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

RESTRICTION OF RECORD: You may ask us not to use or disclose part of the personal health information. This request must be in writing. MCC is not required to agree to your request if we believe it is in your best interest to permit use and disclose of the information. The request should be given to the Practice Manager who will consult with the staff involved in your care to determine if the request can be granted.

CONTACTING YOU: You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have the right to verify the payment information you are proving is correct. Due to agency policy, we are not able to provide information by e-mail.

AMENDING RECORD: If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Practice Manager and ask for the Request to Amend Health Information Form. In certain cases, we may deny your request. If we deny your request for amendment, you have the right to file a statement stating that you disagree with us. We will then file our response to your statement and it will be added to your record.

ACCOUNTING FOR DISCLOSURES: You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period, no longer than six years, and after April 4, 2003, please submit your request in writing to our Practice Manager. We will notify you of the cost involved in preparing this list

QUESTIONS OR COMPLAINTS: If you have any questions or complaints you may contact our Practice Manager in writing at our office for further information. We will not retaliate against you for filing a complaint

CHANGES IN POLICY: MCC reserves the right to change its Privacy Policy based on the needs of MCC and changes in state and federal laws.