REGISTRATION

Date: _____

PATIENT INFORMATION

Patient Name: _____
Last

_____
First **Middle**

Address: _____

City: _____State: _____
Zip: _____

Home Phone: ( )_____

Cell Phone: ( )_____

Birthdate: _____ Sex: □ M □ F

Age: _____ Marital Status: _____

E-mail: _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Work Phone: ( )_____

Spouse's Name: _____

Birthdate: _____

Spouse's Employer: _____

How did you hear about us?

_____

Whom may we thank for referring you?

_____

EMERGENCY CONTACT INFORMATION:

Name: _____
Relationship: _____
Home Phone: ( )_____
Work Phone: ( )_____

INSURANCE INFORMATION

Subscriber Name: _____

Relationship to Patient: _____

Insurance Co.: _____

Policy #: _____

Group #: _____

Subscriber's Birthdate: _____

Is the patient covered by additional insurance?

□ Yes □ No

If yes, please complete the following:
Subscriber Name: _____
Relationship to Patient: _____
Insurance Co.: _____
Policy #: _____Group #:_____
Subscriber's Birthdate: _____
Subscriber's SS #: _____

ASSIGNMENT OF BENEFITS & RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to **Active Life Chiropractic and Wellness Center, S.C. & Dr. Elizabeth E. Engel** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient or Guardian

_____
Printed name of Patient or Guardian

_____ _____
Date Relationship to Patient

Pt. Name: _____

Health History

Please mark (with an X) in the space before each item if you HAVE or HAD the problem.

__ Arthritis
__ Asthma
__ Anemia
__ Cancer
__ Chicken Pox
__ Concussion
__ Convulsion
__ Diabetes
__ Disc Herniation
__ Digestion Problems
__ Dizziness
__ Emphysema
__ Epilepsy
__ Fibromyalgia
__ Fractures
__ Glaucoma
__ Gout
__ Headaches
__ Heart Problems
__ Hepatitis
__ Hernia
__ High Blood Pressure
__ HIV
__ Kidney Disease
__ Liver Disease
__ Measles
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Muscular Dystrophy
__ Night Sweats
__ Osteoporosis
__ Pacemaker
__ Parkinson's Disease
___ Pneumonia
___ Polio
___ Prosthesis
___ Psychiatric Care
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Scarlet Fever
___ Sinus Trouble
___ Stroke
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors/Growths
___ Ulcers
___ Veneral Disease
___ Drug Abuse
___ Weight Loss/Gain
___ Fatigue
___ Frequent Urination
___ Sexual Difficulties
___ Difficulty Starting Urine Flow
___ Inability to control Urine Flow
___ Fainting

Are you currently diagnosed with any health condition(s)? Yes No
_____
_____
_____

WOMEN ONLY

___ Live Births
___ Miscarriage
___Painful Periods
___ Excessive Flow/Heavy Bleeding
___Vaginal Pain/Infection
___ Irregular Cycles
___ Vaginal Burning/Itching
___ Hot Flashes
___ Breast Pain/Lumps/Cysts
___ Ovarian/Uterine Cysts

Date Last Period Began: _____ **Date of Last PAP Test:** _____
Date of Last Mammogram: _____
Are you pregnant? □ **Yes** □**No** **Due Date:** _____

MEN ONLY

___ Testicular Swelling/Pain
___ Prostate Problems
___ Impotence

ACCIDENTS/TRAUMA

___ Motor Vehicle Accidents
___ Other Trauma/Accidents

FAMILY HISTORY

___ Diabetes ___ Thyroid Disease/Goiter ___ Tuberculosis ___ High Blood Pressure ___ Cancer
___ Heart Disease ___Kidney Disease ___ Muscle/Bone/Nerve Disease ___Other

Please list if you've ever had any SURGERIES or HOSPITALIZATIONS.

Description/Reason	Date
1. _____	_____
2. _____	_____
3. _____	_____

CURRENT MEDICATION

Medication	Duration
_____	_____
_____	_____
_____	_____
_____	_____

VITAMINS/SUPPLEMENTS

_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

HABITS

□ **Smoking** **Packs/Day** _____ □ **Alcohol** **Drinks/Week** _____
□ **Drug Use** **Type** _____ □ **Coffee/Caffeine Intake** **Cups/Day** _____
□ **Exercise** **Times/Week** _____ □ **High Stress Level** **Reason** _____

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Please mark, with a number, in the space before each item if you HAVE or HAD the problem. 1=Mild; 2=Moderate; 3=Severe
Patient Name: _____

Musculoskeletal:
__ Low Back Pain
__ Pain between Shoulders
__ Neck Pain
__ Sexual Difficulties
__ Joint pain/stiffness after rising
__ Walking Difficulties
__ Problems chewing/jaw clicking

Nervous System:
__ Nervousness
__ Paralysis
__ Numbness
__ Forgetfulness
__ Confusion
__ Depression
__ Stress
__ Anxiety

EENT:
__ Vision Problems
__ Dental Problems
__ Sore Throat
__ Ear Aches/Pain
__ Difficulty Hearing
__ Ringing in Ears
__Stuffed Nose

Gastrointestinal/Digestion:
__ Poor/Excessive Appetite
__ Excessive Thirst
__ Frequent Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver Problems
__ Gall Bladder Problems
__ Weight Trouble
__ Abdominal Cramps
__ Gas/Bloating After Meals
__ Heartburn/Indigestion
__ Black/Bloody Stool
__ Colitis
__ Loss for taste for meat
__ Lower Bowel gas after eating
__ Burning Stomach Sensation
__ Mucus in stool
__ Foul smelling gas

Sympathetic Dominance
__ Acidic Foods Upset Stomach
__ Feels chilled often
__ "Lump" in throat
__ Dry mouth-eye-nose
__ Pulse speeds after meals
__ Unable to feel calm
__ Gag easily
__ Strong Light irritates
__ Body temperature rises easily

Parasympathetic Dominance:
__ Muscle/Leg/Toe cramps at night
__ "Butterfly" stomach
__ Eyes/nose water
__ Eyelids swollen/puffy
__ Always hungry
__ Food digests rapidly
__ Frequently hoarse
__ Irregular breathing
__ Difficulty swallowing
__ Pulse slow/irregular
__ Perspire easily
__ Poor circulation/cold easily
__ Subject of colds, asthma, bronchitis

Cardiovascular:
__ Chest pain/tightness
__ Shortness of breath
__ Irregular heartbeat
__ Heart problems
__ Lung problems/congestion
__ Varicose veins
__ Ankle swelling
__ Stroke
__ Bruise easily
__ Tendency to anemia
__ Hands & feet "go to sleep" easily
__ Sighs frequently

Liver/Biliary:
__ Dry skin
__ Burning feet
__ Blurred vision
__ Itchy skin/feet
__ Excessive hair falling out
__ Frequent skin rashes
__ Bitter/metallic taste in mouth
__ Bowel movements painful/difficult
__ Feeling of worry, dread, insecurity
__ Feeling queasy
__ Greasy foods upset
__ Stools are light colored
__ Skin peels on foot soles
__ Pain between shoulder blades
__ Using laxatives
__ Stools alternate from soft to watery
__ History of gallbladder attacks or gall stones
__ Sneezing attacks
__ Dreaming, nightmares
__ Bad breath (halitosis)
__Milk products cause distress
__ Burning or itchy anus
__ Sensitive to hot weather

Thyroid:
__ Insomnia
__ Can't gain weight
__ Intolerance to heat
__ Highly emotional
__ Flushes easily
__ Skin thin/moist
__ Heart palpitates
__ Noticeable weight gain
__ Decreased appetite
__ Easily fatigued
__ Sensitive to cold
__ Dry or scaly skin
__ Mental sluggishness
__ Hair coarse, falls out
__ Slow pulse

Pituitary:
__ Increased sex drive
__ Abnormal thirst
__ Weight gain at hips/waist
__ Sex drive reduced/lacking

Adrenals:
__ Acne worse with menses
__ Lightheaded if meals delayed
__ (Female) Hair growth on face/body
__ (Female) Masculine tendencies
__ Chronic fatigue
__ Low energy in morning
__ High energy at night/bedtime
__ Waking up at night/insomnia
__ Crave salt
__ Low blood pressure
__ Weak or rigid nails
__ Arthritic tendencies
__ Perspiration increase
__ Brown spots or bronzing of skin
__ Allergies-tendency towards asthma
__ Weakness after colds, flu
__ Respiratory disorders

Sugar Handling:
__ Get "shaky" if hungry
__ Crave carbs/sweets
__ Afternoon headaches
__ Heart palpitates if meals missed
__ Upset feeling from excessive sweets
__ Crave caffeine/coffee in afternoon
__ Hungry shortly after eating
__ Depressed, "blues", melancholy

Sleep Habits: How do you sleep?
__ Well
__ Trouble falling asleep
__ Trouble staying asleep
__ You wake up tired

Dietary History: Please fill in examples of each meal:
Breakfast:_____
_____
_____
Lunch:_____
_____
_____
Dinner:_____
_____
_____

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ACTIVE LIFE CHIROPRACTIC AND WELLNESS CENTER, S.C.

PRIVACY CONSENT/HIPAA

For use and/or disclosure of protected health information to carry out treatment, payment and healthcare operations.

Active Life Chiropractic and Wellness Center (ALCWC) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

*** If you would like to read the complete version of ALCWC's Privacy Notice please request to do so before signing this consent form.**

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the ALCWC to provide treatment to me, and also necessary for the ALCWC to obtain payment for that treatment and to carry out is health care operations. ALCWC explained to me that the Privacy Notice will be available to me in the future at my request. ALCWC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. ALCWC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by ALCWC: a) a postcard or letter mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) email to the email address provided by me.

4. ALCWC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for ALCWC to treat me and obtain payment for that treatment, and as necessary for ALCWC to conduct its specific health care operations.

5. I understand that I have a right to request that ALCWC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, ALCWC is not required to agree to any restrictions that I have requested. If the ALCWC agrees to a requested restriction, then the restriction is binding on ALCWC.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that ALCWC has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, ALCWC has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then ALCWC will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

To be completed by the patient:

_____
Name of Individual (Printed)

_____
Signature of Individual

Date Signed ____/____/____

To be completed by the patient's representative or legal guardian:

_____
Print name of patient

_____
Print name of legal guardian

_____
Signature of legal guardian/Relationship to patient

ACTIVE LIFE CHIROPRACTIC AND WELLNESS CENTER, S.C.

RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician. YES NO
If yes, please fill out the following:
Patient / Parent Signature_____Date_____
Physician's Name_____
Address_____
Phone Number_____

COMMUNICATION POLICY AND WAIVER

Communication is a very important part of providing quality health care. In an effort to provide you with timely information regarding your health care, we ask that you complete the following information:

May we leave information on your answering machine at home:

Medical information: Yes / No Appointment confirmation: Yes / No

May we call you at:

Home: Yes / No Work: Yes / No Cell phone: Yes / No

May we leave a message at your place of employment? Yes / No

May we e-mail information to you:

Medical information: Yes / No Appointment confirmation: Yes / No
E-mail address:_____

Do you give our office permission to discuss your medical information with family members?

No / Yes (if yes, please provide name below)
Name_____Relationship_____
Name_____Relationship_____
Name_____Relationship_____

I understand the information provided on this communication waiver will remain in effect until revoked by me. I understand that I may revoke this consent at any time by written notice to the practice. I understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

Patient Signature_____Date_____

ACTIVE LIFE CHIROPRACTIC
AND
WELLNESS CENTER, S.C.

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or the patient named below, for whom I am legally responsible) by Elizabeth E. Engel, D.C. (the "Doctor") and/or other licensed Doctors of Chiropractic or those working at Active Life Chiropractic and Wellness Center who now, or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor.

I understand chiropractic care contributes to my overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many other medical or other treatments, medications and procedures given for the same symptoms.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of the possible complications which have been alleged. These include, but are not limited to, fractures, disc injuries, sprains, increased symptoms, pain, no improvement of symptoms or pain, and in extremely remote conditions strokes.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the Doctor at the time; that it is not reasonable to expect the Doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which she/he feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. 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 at Active Life Chiropractic and Wellness Center.

To be completed by the patient:

_____
Name of Individual (Printed)

_____
Signature of Individual

Date Signed ____/____/____

To be completed by the patient's representative or legal guardian:

_____
Print name of patient

_____
Print name of legal guardian

_____
Signature of legal guardian/Relationship to patient

ACTIVE LIFE CHIROPRACTIC AND WELLNESS CENTER, S.C.

FINANCIAL POLICY

Thank you for choosing Active Life Chiropractic and Wellness Center for your chiropractic needs. We are committed to your treatment being a success. Please understand that payment of your bill is considered part of your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH ELIZABETH E. ENGEL, D.C. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER CARD.

IF YOU HAVE INSURANCE

We may accept your insurance benefits on assignment after your insurance has been verified. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations. This is your responsibility and obligation. **All charges incurred are your responsibility**. If you have a question or problem with the reimbursement level, contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

- All insurance verifications of coverage are not a guarantee of benefits.
- All co-pays and non-covered insurance services will be due at the time the service is rendered.
- Active Life Chiropractic and Wellness Center will do its best to monitor your benefit maximums, but ultimately you are responsible for keeping track of your own benefit maximums through your insurance company as well as any changes throughout the yea
- If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.
- If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance company has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

IF YOU DO NOT HAVE INSURANCE

All payments are due at the time of service.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENTS

All payments, which include, but are not limited to, co-insurances and deductibles, are due within thirty (30) days of the monthly billing date unless prior arrangements have been made with Elizabeth E. Engel, D.C..
A service charge of 1.5% per month will be applied on any balance over sixty (60) days. If payment is not received after ninety (90) days, the patient is in default and is responsible for collection, filing, court or attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

I have read, understand and agree with this financial policy.

X_____ _____

Signature of patient or guardian Date

Active Life
Chiropractic AND Wellness Center
A Perfect Balance of Health & Wellness

Effective 01/01/23:

Active Life Chiropractic and Wellness Center S.C. reserves the right to charge a $50.00 fee for any appointments cancelled or missed or with less than 24-hour notice.

This fee is an out-of-pocket expense, and this is not something that we can bill through your insurance company.

In the future we may be forced to increase our cancellation fee. Before any increase in this fee happens, we will provide you with updates via email (newsletters, videos, etc.), by displaying signs in our office and by Dr. Engel or a member of the Active Life staff informing you about the increase in this fee.

By signing this form, you agree to this current change as well as future changes.

I have read and understand Active Life Chiropractic and Wellness Center, S.C. cancellation policy.

_____
Patient Signature

_____
Patient Name (Please Print)

_____
Signature Date