



NORTH SCOTTSDALE FAMILY  
CHIROPRACTIC

## Chiropractic Case History/Patient Information

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D How many children \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_

Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Have you ever had the same or a similar condition? ( ) Yes ( ) No If yes, when and describe: \_\_\_\_\_

Days lost from work: \_\_\_\_\_ What surgeries have you had? (include dates) \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? ( ) Yes ( ) No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

What services are you interested in? \_\_\_ Chiropractic \_\_\_ Acupuncture \_\_\_ Nutritional Support

Are you looking to: \_\_\_ Get Out of Pain \_\_\_ Fix The Problem \_\_\_ Wellness Care

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

May we add your name to our referral board? ( ) Yes ( ) No

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic services  None  Other \_\_\_\_\_

Name and address of other doctor(s) you have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	__ Yes__ No	Chicken Pox	__ Yes__ No	Liver Disease	__ Yes__ No	Psychiatric Care	__ Yes__ No
Alcoholism	__ Yes__ No	Diabetes	__ Yes__ No	Measles	__ Yes__ No	Reumatoid	__ Yes__ No
Allergy	__ Yes__ No	Emphysema	__ Yes__ No	Migraine	__ Yes__ No	Rheumatic	__ Yes__ No
Shots				Headaches		Fever	
Anemia	__ Yes__ No	Epilepsy	__ Yes__ No	Miscarriage	__ Yes__ No	Scarlet Fever	__ Yes__ No
Anorexia	__ Yes__ No	Fractures	__ Yes__ No	Mono-nucleosis	__ Yes__ No	Stroke	__ Yes__ No
Appendicitis	__ Yes__ No	Glaucoma	__ Yes__ No	Multiple Sclerosis	__ Yes__ No	Suicide Attempt	__ Yes__ No
Arthritis	__ Yes__ No	Goiter	__ Yes__ No	Mumps	__ Yes__ No	Thyroid Problems	__ Yes__ No
Asthma	__ Yes__ No	Gonorrhea	__ Yes__ No	Osteoporosis	__ Yes__ No	Tonsillitis	__ Yes__ No
Bleeding Disorders	__ Yes__ No	Gout	__ Yes__ No	Pacemaker	__ Yes__ No	Tuberculosis	__ Yes__ No
Breast Lump	__ Yes__ No	High Blood Pressure	__ Yes__ No	Parkinson's Disease	__ Yes__ No	Tumors, Growths	__ Yes__ No
Bronchitis	__ Yes__ No	Hepatitis	__ Yes__ No	Pinched Nerve	__ Yes__ No	Typhoid Fever	__ Yes__ No
Bulimia	__ Yes__ No	Hernia	__ Yes__ No	Pneumonia	__ Yes__ No	Ulcers	__ Yes__ No
Cancer	__ Yes__ No	Herniated Disk	__ Yes__ No	Polio	__ Yes__ No	Vaginal Infections	__ Yes__ No
Cataracts	__ Yes__ No	Herpes	__ Yes__ No	Prostate Problems	__ Yes__ No	Venereal Disease	__ Yes__ No
Chemical Dependency	__ Yes__ No	High Cholesterol	__ Yes__ No	Prosthesis	__ Yes__ No	Whooping Cough	__ Yes__ No
		Kidney Disease	__ Yes__ No	Other	_____		

EXERCISE	WORK ACTIVITY	HABITS	Other
__ None	__ Sitting	__ Smoking	Packs/Day _____
__ Moderate	__ Standing	__ Alcohol	Drinks/Week _____
__ Daily	__ Light Labor	__ Coffee/Caffeine Drinks	Cups/Day _____
__ Heavy	__ Heavy Labor	__ High Stress Level	Reason _____

Are you pregnant? \_\_ Yes \_\_ No Due Date \_\_\_\_\_

Injuries/Surgeries you have had:	Descriptions	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

# WELLNESS ASSESSMENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. How important is your health to you?

0-----10  
 (Not Important) (Extremely Important)

2. On the diagram below, mark where *you feel* your health is at today ( with a 0 )

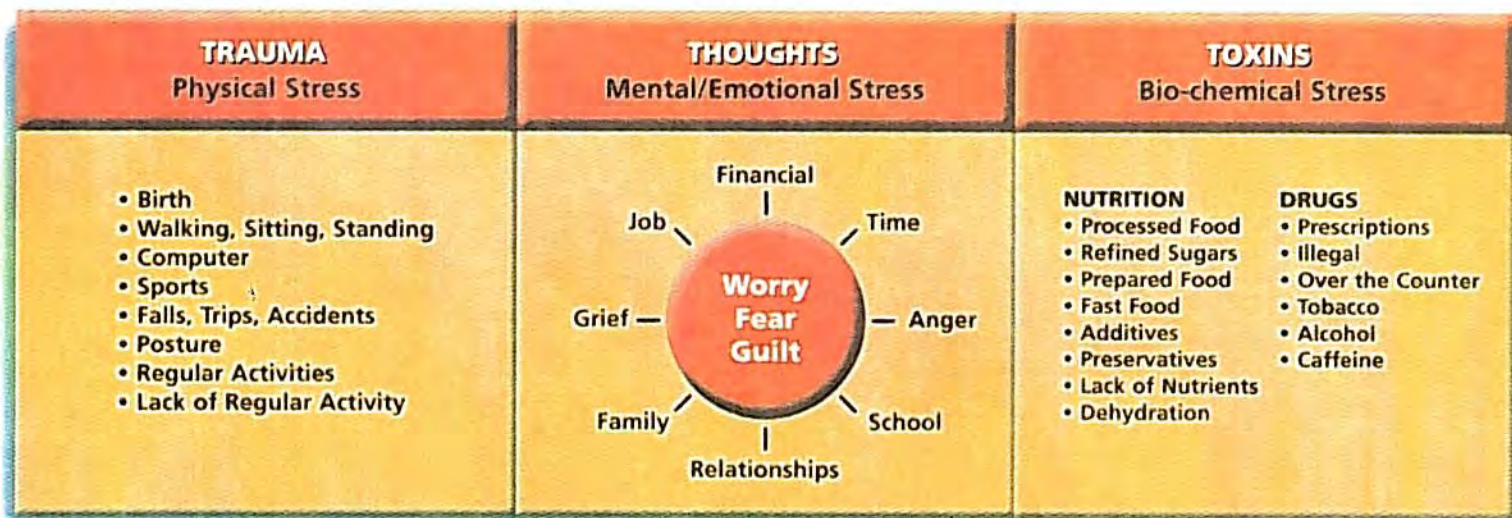


4. How long do you think it might take to get there?

\_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

5. What factors in your life do you think are not allowing you to be as healthy as you would like to be:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_





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8080 E. Gelding Drive Suite D101 Scottsdale, AZ 85260  
Office: (480) 588-5111 Fax: (480) 588-8805

### **OFFICE POLICIES**

If you need to reschedule or cancel an appointment please call our office 24 hours in advance to do so. You will be charged \$25 for missed appointments or cancellations with less than 24 hours notice.

Please refrain from wearing strong colognes/perfumes to our office as many of our patients have highly sensitive allergies and/or respiratory problems.

Please notify the doctor of any changes in health status, regardless of the significance.

Please notify the staff of any changes in your insurance coverage.

A balance is not to exceed \$100.

### **FINANCIAL POLICIES**

#### **PATIENTS WITHOUT INSURANCE**

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your cash, checks and credit cards.

#### **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.

#### **"ON THE JOB" INJURY (Worker's Compensation)**

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

#### **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. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.



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## MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

## SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

*I have read and understand the payment policy of North Scottsdale Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between North Scottsdale Family Chiropractic and my insurance company. I request that North Scottsdale Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. If the insurance company does not pay their portion within 45 days we expect you to contact them to insure that the claim gets paid. If the insurance company sends a check directly to you, it should be brought to our office as soon as possible. You may also be sent a monthly statement with your account balance. Please call us with any financial concerns or challenges. 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 the doctors at North Scottsdale Family Chiropractic that fees will be due and payable immediately. Any additional collection fees will be the patient's responsibility.*

\_\_\_\_\_  
Patient's signature (or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness



Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

### Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

It is important that each patient understand both the objective and the method that will be used to attain improved spinal health. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific, gentle, manual adjustments of the spine. In some cases an adjusting instrument (an activator) will be used at the discretion of the doctor.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of symptoms.

**Vertebral Subluxation:** A misalignment of one or more of the twenty-four vertebra in the spinal column which can cause alteration of nerve function and transmission of nerve impulses resulting in a lessening of the body's ability to perform at its optimal potential.

We only offer to diagnose either vertebral subluxations or neural-musculoskeletal conditions of the body, however, if during the course of the chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. We have a list of other professional health care providers for referral purposes if indicated.

I, \_\_\_\_\_ have read and fully understand the above statements. All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis, and understand that all charges incurred are my responsibility.

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)

**\*\*Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_ being the parent/legal guardian of \_\_\_\_\_ have fully read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Thomas V. Tuzzolino, D.C., F.I.A.M.A.

\_\_\_\_\_  
(authorized signature)

\_\_\_\_\_  
(date)

**\*\*Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform, if needed, an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. *Date of last menstrual period:* \_\_\_\_\_

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)



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## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, 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 or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel 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, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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.

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 Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## PROTOCOL FOR PRESERVATION OF PATIENT RECORDS

Pursuant to ARS 32-3211 and the requirements for the State of Arizona for the preservation of patient records, this document is intended to inform all patients of North Scottsdale Family Chiropractic of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. North Scottsdale Family Chiropractic agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

North Scottsdale Family Chiropractic will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, North Scottsdale Family Chiropractic reserves the right to destroy your records. Should North Scottsdale Family Chiropractic exercise that right, North Scottsdale Family Chiropractic will first attempt to contact you and inform you of your right to obtain a copy of these records. North Scottsdale Family Chiropractic will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should North Scottsdale Family Chiropractic retire, cease to practice, or sell the practice to another health care professional, North Scottsdale Family Chiropractic will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

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Patient Signature

I acknowledge receipt of this document