WELCOME TO INFINITY SPINE CENTER

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Email: _____

Date of Birth: ____ / ____ / _____ Sex: ☐ M ☐ F **Height:** _____ - _____ **Weight:** _____

Spouse's name: _____ Phone: _____

Emergency Contact (if other than spouse): _____ Phone: _____

How did you hear about us/whom may we thank for referring you? _____

Have you had an accident (major or minor) within the past 2 years? ☐ NO ☐ Yes Date: _____

If yes, what type of accident? ☐ AUTO ☐ WORK ☐ Other: _____

If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the front desk for the "accident questionnaire" at the time.

Are you seeking care due to an auto or work injury? ☐ NO ☐ Yes Initial Here: _____

Do you have primary health insurance policy? ☐ NO ☐ Yes Do you have a Secondary Policy? ☐ NO ☐ Yes

If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. ***Most insurance companies cover our services.***

Policy Holder's Name: _____ DOB: ____ / ____ / _____ SSN: _____

Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Legally Separated

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ~ Student Status: ☐ Full-time ☐ Part-time ☐ Non-student

Employer: _____ Occupation: _____

I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary.

Initial Here: _____

The initial visit will include a history and extended examination. Day two will consist of a report of findings and your initial adjustment with Dr. John P. Thoma, D.C. If you are here due to an accident, the regular fees for today's visit will be paid in full by auto or worker's compensation insurance.

If your claim is denied, we will ask you to pay for today's visit.

NOTE FOR WOMEN: It is important to inform the doctor or staff if you are pregnant.

AUTHORIZATION FOR HEALTH CARE SERVICES:

I authorize Infinity Spine Center to administer chiropractic care, including but not limited to examinations, adjustments, and therapies.

_____ _____ _____

Signature of Patient/Guardian **Print Name** **Date**

HEALTH HISTORY QUESTIONNAIRE

PATIENT'S FULL NAME: _____

Are you pregnant? N/A (male) Unsure No Yes Due Date: ____ / ____ / _____

Have you had x-rays within the last year? No Yes If Yes, date: ____ / ____ / _____

Reason: _____

Doctor's name & phone where x-rays were taken: _____

List any medications (including birth control) or vitamins you are currently taking:

_____

_____

_____

List Allergies: _____

List Fractured Bones: _____

_____

List Surgeries or Transplants: _____

_____

List major/minor accidents trauma: _____

_____

Do you have any concerns about chiropractic care? ☐ No ☐ Yes

Do you have any concerns about therapy/rehabilitation? ☐ No ☐ Yes

If Yes, please explain: _____

_____

Check all that apply:

☐ Headaches	☐ Osteoporosis	☐ Hearing Problems	☐ Depression	☐ Ringing in Ears
☐ Neck Pain	☐ Sore Throats	☐ Aortic Aneurysm	☐ Dizziness	☐ Vision Problems
☐ Shoulder Pain	☐ Nervousness	☐ Heart Disease	☐ Trauma	☐ Low Blood Pressure
☐ Upper Back Pain	☐ Seizures	☐ Kidney Problems	☐ Cold	☐ High Blood Pressure
☐ Mid-Back Pain	☐ Loss of Energy	☐ Cancer/Tumor	☐ Diarrhea	☐ Digestive Trouble
☐ Low-Back Pain	☐ Constipation	☐ Gall Bladder Issues	☐ HIV/AIDS	☐ Asthma/Weak Lungs
☐ Hip Pain	☐ Muscle Cramps	☐ Prostate Issues	☐ Diabetes	☐ Urinary Tract Infections
☐ Leg Pain/Cramps	☐ Arthritis/ Rheumatism	☐ Difficulty Sleeping	☐ Tonsillitis	☐ Stroke (date): _____

☐ Back/Spinal Condition, please describe disorder: _____

☐ Abnormal Weight Gain / Loss ☐ Other: _____

Family Medical History: Please check all the apply

☐ Cancer ☐ Stroke ☐ Seizures ☐ Diabetes ☐ Abnormal Blood Pressure

☐ Osteoporosis ☐ Cardiovascular Disease ☐ Other: _____

HEALTH HISTORY QUESTIONNAIRE

Current Chief Complaint:

Are you here for: ☐ a check up ☐ a specific problem: _____

What were you doing when this complaint first appeared? _____

What date did your chief complaint begin? _____ / _____ / _____

Have you had this complaint before? ☐ No ☐ Yes, _____

Where specifically is your complaint located? _____

Is you complaint: ☐ Constant ☐ Comes and Goes ☐ Other: _____

What activities make your complaint better? _____

What activities make your complaint worse? _____

What position relieves this complaint? _____

How often is your complaint present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Does this complaint interfere with work/living habits? ☐ No ☐ Yes, _____

What have you done for this complaint? _____

Check each box that describes the chief complaint you discussed above:

☐ Dull Pain ☐ Sharp Pain ☐ Numbness ☐ Tingling ☐ Stiff ☐ Throbbing ☐ Aching

☐ Shooting ☐ Burning ☐ Cramping ☐ Swelling ☐ Redness ☐ Radiating _____ to _____

Please indicate your pain level on this scale: **0 = no pain…up to…10 =intolerable pain**

0	1	2	3	4	5	6	7	8	9	10

My complaint is: Better in the: ☐ AM ☐ MIDDAY ☐ PM ☐ Never Lessons

Worse in the: ☐ AM ☐ MIDDAY ☐ PM ☐ Constant

Does your complaint interfere with your sleep? ☐ No ☐ Yes

Have you consulted/received other treatments for your chief complaint? ☐ No ☐ Yes

If yes, what treatments: _____

_____

Result of treatments: _____

_____

Name/ Phone number of treating doctor: _____

Treating doctor's specialty: _____

Are there any other problems/pains that you wish to address during this visit? ☐ No ☐ Yes

_____

_____

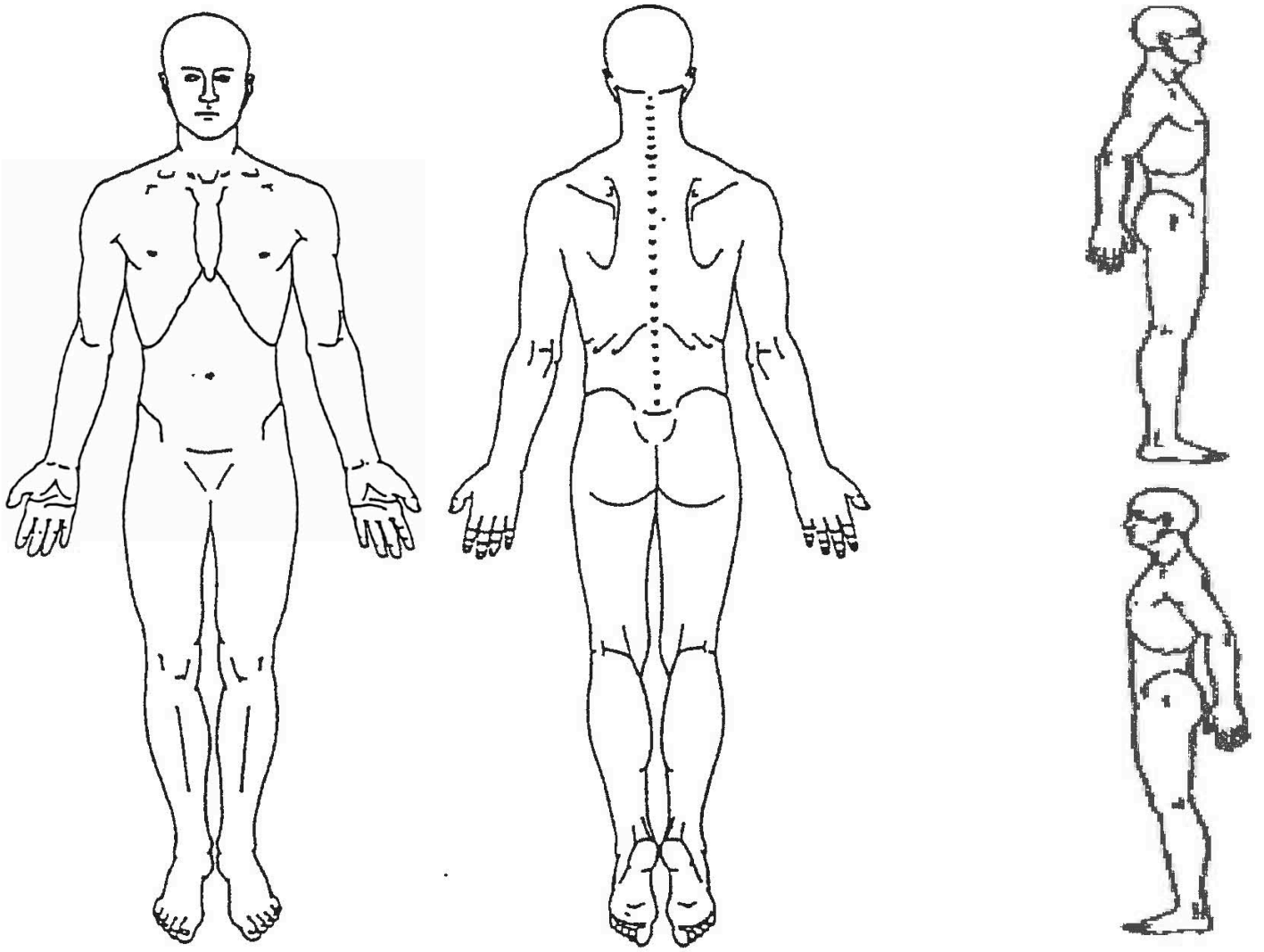
_____

_____

Pain Diagram

Draw In Areas Of Pain On Body Diagram Using Appropriate Symbols.

Severe Pain	******	**Moderate Pain**	000000	**Dull Ache**	◊◊◊◊◊◊
Radiating Pain	↓↓↓↓↓↓	**Numbness/Tingling**	XXXXXX		



Comments/Notes:

By signing below, I hereby certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

Signature of Patient/Guardian	**Print Name**	**Date**

HIPPA Health Care Authorization Form (Privacy Practices)

All information you provide us with is confidential in nature and will only be referenced or shared with you, insurance companies, providers and billing or legal facilities who provide us with a signed request. By signing this form I give permission to **Dr. John P. Thoma, D.C.'s** Office to use all information I provide, as this office deems appropriate. This consent shall be in force and effect as long as I am a patient at this practice. In addition, I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician at this practice.

In addition, by signing below I give this office permission to:

- Send me correspondence and provide me with health & other related information.
- Call and/or leave messages for me on an answering machine and/or voicemail.
- Provide health care professionals & others with my information when requested.
- Allow staff and other patients to view my name on the sign in register/sheet.
- Treat me in a semi-open room where others may see me if passing by in the hall.
- File a health care provider lien to bind insurance companies to forward payment.
- Display any testimonials I may write.
- Forward to/request my records from providers, attorneys & insurance companies.
- Speak to my insurance company on my behalf.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

I authorize the following individual(s) to have access to the information on my account:

☐ Anyone calling on my behalf requesting appointment & billing information

☐ These people specifically (spouse, parents, sibling, children, office assistants, accountants, etc)

_____ _____

_____ _____

_____ _____

☐ I do not authorize anyone but myself to have access to my information at this office.

Per HIPAA rules and regulations, unencrypted email is not considered a secure way of communication, although many of our patients prefer email as a way to communicate with us.

Would you like Infinity Spine to be able to send correspondence/billing info/etc via email? ☐ Yes ☐ No Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Please feel free to read the binder provided at the front reception desk. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- I have the right to review the notice prior to signing this consent.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

The patient identified below authorizes Dr. John Thoma, D.C.'s Office to use and disclose protected health information in accordance with all items described. This authorization shall expire on the following date: *No Expiration Date*

_____ _____

Print Patient Name **Date of Birth:**

_____ _____ _____

Signature of Patient/Guardian **Print name of Guardian (if applicable)** **Date**

INFINITY SPINE CENTER
Dr. John P. Thoma, D.C.
8080 E Gelding, Scottsdale, Arizona 85260
Phone: 480.656.6200 Fax: 480.625-3511

Informed Consent for Chiropractic Care and Lifestyle Advice

When a patient seeks chiropractic health care and lifestyle advice and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care of this basis.

Signature of Patient	**Print Name**	**Date**

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

I _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature of Parent/Guardian	**Print name of Parent/Guardian**	**Date**

Pregnancy Release - For Female Patients ***only***:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature of Patient	**Print Name**	**Date**

INFINITY SPINE CENTER
Dr. John P. Thoma, D.C.
8080 W. Gelding, Scottsdale, Arizona 85260
Phone: 480.656.6200 Fax: 480.625.3511

First Name: _____ Last Name: _____

FEES FOR SERVICES RENDERED: Infinity Spine Center offers a discounted price available for payment at the **Time of Service (TOS)** on all services to all patients. This discount reflects the money we save by not having to bill and collect for our services, and we pass the savings on to you. This discount is only available if payment is made at the time of service. If we have to bill and collect for our services we charge the standard prices.

Time of Service (TOS) Fees		**Nutrition Consultation**	
Initial new patient evaluation	$ 150	Initial new patient evaluation	$ 125
Maintenance/wellness visit	$ 70	Maintenance/wellness visit	$ 60
Standard Fees for Service			
Initial new patient evaluation	$160 - $185	Therapeutic Exercise	$ 60
Extended Daily Re-Exam of Patient	$ 85 - $135	Neuromuscular Re-Education	$ 60
Spinal Adjustment	$ 60 - $ 70	Myofascial Release	$ 70
Electrical Stimulation	$ 50	Strapping – Lumbar	$ 75
Extremity Adjustment	$ 50	Strapping – Shoulder	$ 75
Activities of Daily Living - Function	$ 70	Lumbar Orthosis	$ 30
Massage Therapy	$ 75		
Acupuncture	$ 60		
Missed Appointment Fees		**Red/Near Infrared Light Therapy**	
Chiropractic	$ 60	R/NIR Light Therapy	$ 20
Returned Check Policy:	$ 60	3 X Week (Monthly)	$180
		Package of 8 (Expires in 4 Months)	$120

I understand the average daily office visit fee applied to all insurance companies is approximately $200.00. I understand each code and/or multiple codes will be billed to my insurance company on the same date of service. I accept these fees and understand the doctor is to be paid in full for all services I receive. I understand, as a service to me, the doctor pays a billing service and a documentation service then awaits reimbursement from my insurance company. By signing below, I acknowledge I am responsible for giving Infinity Spine all insurance checks sent to me directly. **I am only responsible for a daily co-payment and, if applicable, payments(s) toward my annual deductible**, while my health insurance is being billed.

I understand if my care is associated with an auto, work, injury or accident claim, all bills will be paid at 100% of the above fee schedule **regardless** of the outcome of my case. I understand automobile insurance and worker's compensation insurance pays for the accident care in full. **Most auto and work injury care is provided at no out of pocket cost to me.**

I further agree, if any insurance company refuses payment, I authorize the doctor to file suit in small claims court, on my behalf, against the insurance company, as a method of collection. I agree to be present at the court date if needed. I also agree to filing a lien with all insurance companies responsible for payment. **I have fully read and understand these terms and fees (sign below).**

*Services other than those provided on routine office visits may be charged separately. Fees are subject to change without notice. Certain conditions may require more services rendered. In such case, they will be explained to you before they are preformed.

Missed Appointment Policy

We have a Missed Appointment Policy because we do not double-book our appointments. We are reserving time in our office exclusively for you. If you are unable to keep your appointment, please give 24 hours notice in advance. If less than 24 hours notice is given, you will be charged a Missed Appointment Fee. **If I am late to my appointment and the doctor or office staff feels I will not have time to receive proper care, I will be charged a missed appointment fee and will be asked to reschedule**. We also respect your time. If we cancel your appointment with less than 24 hours notice (unless related to illness), we will credit your account for the amount of a Missed Appointment Fee.

_____ _____ _____

Signature of Patient/Guardian **Print Name** **Date**