

**DR. RONALD L. ROSQUIST D.C.
SOUTH VALLEY CHIROPRACTIC**

PATIENT INFORMATION (please print)

Last Name _____ First _____ Middle _____
Address _____ City _____
State _____ Zip Code _____ Home Phone _____ Cell # _____
Employer _____ Work Phone _____
Address _____
Birthdate _____ Present Age _____ Driver's License _____
Social Security # _____ Male Female
 Married Single Divorced Separated Widowed
E-mail address _____
Whom can we thank for referring you to this office? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____
Address _____ Home Phone _____
Employer _____ Work Phone _____
Social Security _____ Driver's License _____
Spouse's Name _____ Social Security # _____
Spouse's Employer _____ Spouse's DOB _____

IN CASE OF EMERGENCY CONTACT

Name of nearest relative not living with you: _____
Address _____ Phone _____

INJURY INFORMATION

Date of Accident/Injury/Illness _____
Explanation of Accident or chief complaint _____

PATIENT PAYMENT POLICY

The patient must provide verification of Insurance AT TIME OF SERVICE or Patient will be charged cash for services. Cash patients must pay at time of service to receive a courtesy discount. No payment at time of service we result in full charge for services rendered. All visits will be paid in full at time of service.

CONSENT TO TREAT AND RELEASE

I understand that the treatment I receive from Dr. Rosquist and his staff may require them to come into physical contact with my body in order to properly perform chiropractic manipulation, acupuncture, ultrasound or other treatment modalities. I also understand that some treatment modalities may cause me some physical discomfort during and/or following treatment or may invade my sense of privacy. I hereby voluntarily consent to Dr. Rosquist and his staff providing me such treatment as judged necessary by them and release them from any and all liability for doing so except for damages caused to me by their gross neglect.

ASSIGNMENT OF INSURANCE BENEFITS – RELEASE OF PRIVATE INFORMATION

I hereby assign my right to payment for services rendered from my insurance company to South Valley Chiropractic, Inc. I authorize them to act on my behalf to process claims with my insurance company and to receive payment for the treatments they perform. I further authorize Dr. Rosquist and his staff to release confidential medical information to my insurance company as needed to process the insurance claims.

FINANCIAL TERMS AND PROMISE TO PAY

I agree to pay for all services performed on my behalf by Dr. Rosquist and his staff. I understand that my insurance may not pay for all charges and I agree to promptly pay for all services rendered regardless of what amount my insurance actually covers. I understand and agree that payment is due at the time service is rendered.

TERMS

In the event that I do not pay for the services rendered on my behalf at the time of service, I agree to pay a finance charge on the unpaid balance at the rate of eighteen percent annual percentage rate (18% A.P.R.). Should the services of a collection agency or attorney be required to enforce my payment obligation, I agree to pay an additional collection surcharge equal to forty percent (40%) of my balance plus all attorney's fees and court costs incurred, with or without suit, to do so.

Signed

Date

Office Use Only

- 1
- 2-5
- >5

WILTSE et. al.

Patient #: _____

PAIN DRAWING

Name: _____ Todays Date: _____

Date of Birth: _____ Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>
>>>>

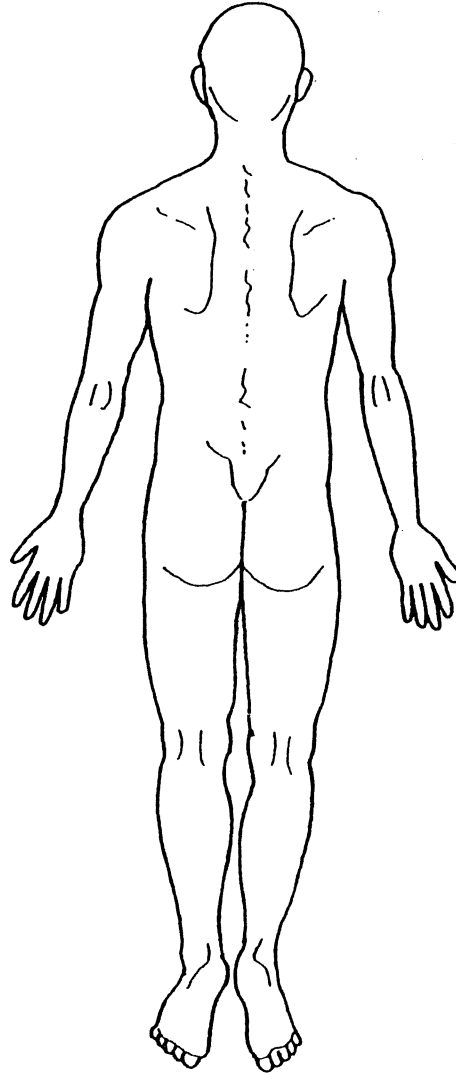
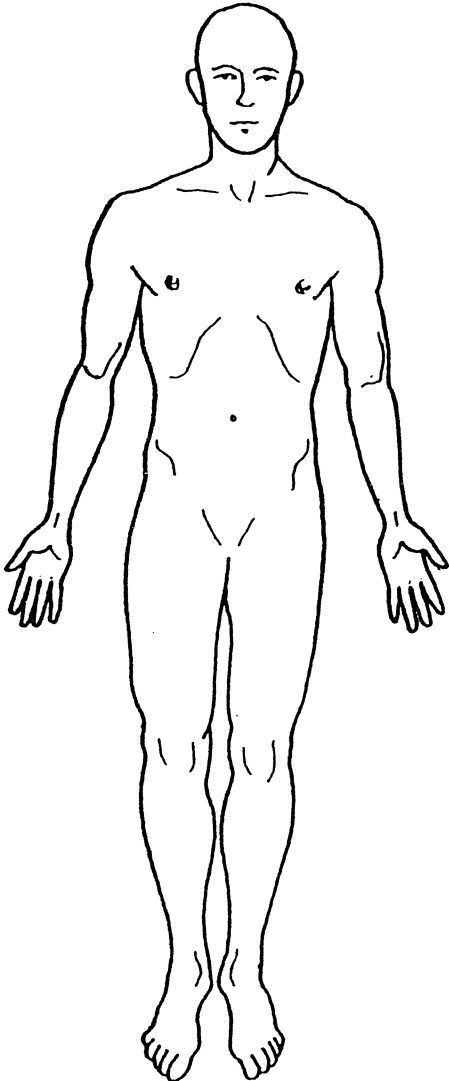
Numbness =====
=====

Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~



DALLAS PAIN QUESTIONNAIRE

Name: _____

Today's Date: _____

Date of Birth: _____

Examiner: _____

Please read carefully: This questionnaire has been designed to give your doctor information as to how your pain has affected your life. Be sure that these are your answers. Do not ask someone else to fill out the questionnaire for you. Please mark an "X" in the appropriate box that expresses your thoughts from 1 to 100 in each section.

Section I: Pain and Intensity

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None Some All the time

0% (_____) 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

None (no pain) Some I cannot get out of bed

0% (_____) 100%

Section III: Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) Some I cannot lift anything

0% (_____) 100%

Section IV: Walking

Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same Almost the same Very little I cannot walk

0% (_____) 100%

Section V: Sitting

Back pain limits my sitting in a chair to?

None, pain same as before Some I cannot sit at all

0% (_____) 100%

Section VI: Standing

How much does your pain interfere with your tolerance to stand for long periods?

None same as before Some I cannot stand

0% (_____) 100%

Section VII: Sleeping

How much does pain interfere with your sleeping?

None same as before Some I cannot sleep at all

0% (_____) 100%

Section VIII: Social Life

How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None same as before Some No activities total loss

0% (_____) 100%

Section IX: Traveling

How much does pain interfere with traveling in a car?

None same as before Some I cannot travel

0% (_____) 100%

Section X: Vocational

How much does pain interfere with your job?

None No interference Some I cannot work

0% (_____) 100%

Section XI: Anxiety/Mood

How much control do you feel that you have over demands made on you?

(No change) Total Some None

100% (_____) 0%

Section XII: Emotional Control

How much control do you feel that you have over your emotions?

(No change) Total Some None

100% (_____) 0%

Section XIII: Depression

How depressed have you been since the onset of pain?

Not depressed significantly Overwhelmed by depression

0% (_____) 100%

Section XIV: Interpersonal Relationships

How much do you think your pain has changed your relationships with others?

Not changed Drastically changed

0% (_____) 100%

Section XV: Social Support

How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)?

None needed All the time

0% (_____) 100%

Section XVI: Punishing Responses

How much do you think others express irritation, frustration or anger toward you because of your pain?

None Some All the time

0% (_____) 100%

Dr. Ronald Rosquist
South Valley Chiropractic PC
834 East 9400 South , Suite 57
Sandy, UT 84094

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- **We may need to use your personal information to remind you of your appointments, send you a welcome to our office, send you an office newsletter, or send promotional information.**

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

We will not provide your health information to any individual, company, or organization without your signed authorization except as mentioned above.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Print Patient's Name

Authorized Provider Representative

Signature

Date

Date