1007 Harbor Hills Drive, Suite B
Marquette, MI 49855
906-225-8011

Welcome to Horizon HealthWorks!

Your new patient forms are attached. Please fill them out and return them to our office **two weeks before your initial examination**. This maximizes your time with your physician by allowing time to review your health history prior to your appointment. Returning forms promptly not only indicates your commitment to your appointment but are primarily requested so if an earlier appointment date for your evaluation becomes available, we may be able to get you in sooner. You may return forms using any of the four means listed below:

- Scan and **E-MAIL** them to helpdesk@horizonhealthworks.com
- **FAX** completed forms to 906-225-8033
- Hand **DELIVER** completed forms to our office. Call ahead for office hours or place in our mailbox (Suite B) located to the right of the building's exterior doors
- Print & **MAIL** them to 1007 Harbor Hills Dr. Ste B Marquette, MI 49855

Imaging and Physician Records: For your convenience, a medical release form is included within the new patient forms. Please fill out the release form and list all physicians you have seen relevant to your condition. Our office will then contact your previous physicians and request your records be returned to us prior to your appointment. Previous medical records allow us to further understand your medical history and allow us to provide you with the best care possible.

Attire for examination: Please wear appropriate clothing for the examination. For example, if you're experiencing knee pain wear pants that easily roll up or shorts.

We would be more than happy to answer any questions that you might have in regards to our services or the new patient exam process. Please contact us at (906) 225-8011 or by e-mail at helpdesk@horizonhealthworks.com. Our office is located off of South McClellan Street at 1007 Harbor Hills Drive (Suite B). We share a building with Forefront Dermatology.

We look forward to being your partner in assisting you in your health goals!

1007 Harbor Hills Drive, Suite B
Marquette, MI 49855
(p) 906-225-8011
(f) 906-225-8033

Medical Information Release to Horizon HealthWorks

This authorization for use or disclosure of my health information is required by state and federal law.

Patient Name (last,first,middle)____
Date of Birth: ______________ Phone Number: _________________________________
Address: _______________________________ City/State/Zip: _____________________
____

I, _________________hereby authorize the use or disclosure of my health information to Horizon Healthworks, P.C. in accordance with state and federal laws, from:

<u>Please list ALL physicians you have seen for the condition for which you are seeking treatment for at Horizon HealthWorks</u>

Physician Name, Office Location	Fax Number

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

____
Patient's or Legal Representative's Signature* Date

____
Relationship if Other Than Patient

Please Print Today's date:				Primary Physician:			

Patient Information

Last name:	First: MI:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status ☐Single ☐ Married ☐Div ☐Sep ☐Wid Date of birth:	
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):			Sex: ☐M ☐ F
Street address:				Primary Phone #: ( )	
City:	State:	ZIP Code:		Alternate Phone #: ( )	
Occupation:	Employer: Email Address:			Employer Phone #: ( )	
How did you hear about us? (please check one box):	Dr.				
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Facebook	☐ Other
Name (if applicable):					

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone	Cell Phone

Date of New Patient Appointment: _____/____/_____ Injury/Onset Date: _____/____/_____

Have you had any diagnostic testing/imaging within the last 5 years?

If yes, please list date of each test/imaging:

Please have your records faxed to our office at: 906-225-8033

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6

History of Present Condition/Mechanism of Injury:

When did you first notice this condition?
Did it begin: ☐ Immediate or ☐ Gradually? Briefly Describe:

Please list what doctors you have seen for this condition. (Please include diagnosis, treatment, and any changes in your condition)

Please check the appropriate box:

Have you had surgery?	☐ Yes	☐ No	Explain:
Have you been hospitalized?	☐ Yes	☐ No	Explain:
What was your diagnosis?			List:
What side is affected?	☐ Right	☐ Left	N/A
Do you have specific physician orders?	☐ Yes	☐ No	Explain:
Do you have a history of falls?	☐ Yes	☐ No	Injuries:
Current level of function?	☐ Good	☐ Poor	Other:

Prior Level of Function: Are you ***independent*** in the following?

Activities of Daily Living (ADLs)	☐YES	☐NO
Self Care	☐YES	☐NO
Work/Vocation	☐YES	☐NO
Mobility	☐YES	☐NO
Community Integration	☐YES	☐NO

Functional Limitations: **(Check if you have had or currently have a problem with the following)**

Sleep	☐	Gripping	☐
Self-Care	☐	Bright Lights	☐
ADLs	☐	Coughing/Sneezing	☐
Reaching/Pushing/Pulling	☐	Mobility/Ambulation	☐
Lifting/Carrying	☐	Mental Activities	☐
Sitting/Standing	☐	Community Integration	☐
Bending/Squatting	☐	Others:	☐

Please check all that apply:

Do you have trouble sleeping?	☐ Yes	☐ No	☐ Staying asleep	☐ Falling asleep
Do you have sleeping disturbances?	☐ Yes	☐ No	☐ Nightmares	☐ Discomfort

Aggravating Factors: (Check if the following aggravate you)

Sitting	☐	Sit to Stand	☐
Standing	☐	Bending	☐
Walking	☐	Voiding	☐
Stairs- Up	☐	Lying Down	☐
Stairs- Down	☐	Coughing/Sneezing	☐

Please check the appropriate box below:

☐ Employed	☐ Married	☐ Retired	☐ Disabled	☐ Student	☐ Unemployed
Name of Employer/Job Title:					

Medical History:

Do you smoke?	☐YES	☐ NO	#/day:
Are you cognitively impaired?	☐ YES	☐ NO	
Do you drink alcohol?	☐ YES	☐ NO	#/day:
Coffee	☐ YES	☐ NO	Cups/day:
Exercise	☐ YES	☐ NO	Times/week:
Water	☐ YES	☐ NO	Cups/day:
Soft Drinks	☐ YES	☐ NO	Amount/day:
Osteoarthritis	☐	Complicating Factors	☐
Cardiovascular Disease	☐	Previous Therapy	☐
Diabetes Mellitus Type 1	☐	Diabetes Mellitus Type 2	☐
Allergies	☐	Psycho-Social	☐
Surgical History	☐	Others:	

General Health History

Check the left box for any condition YOU had in the **P**AST, and the right box for any condition YOU have **C**URRENTLY.

P C	**P C**	**P C**	**P C**
☐ ☐ Mental Disorders	☐ ☐ Diabetes	☐ ☐ Pneumonia	☐ ☐ Infective Disease
☐ ☐ Epilepsy	☐ ☐ Anemia	☐ ☐ Tuberculosis	☐ ☐ Fungal Infection
☐ ☐ Tumors	☐ ☐ Glaucoma	☐ ☐ Hepatitis	☐ ☐ Herpes
☐ ☐ Alcoholism	☐ ☐ Heart Disease	☐ ☐ Thyroid Disease	☐ ☐ Arthritis
☐ ☐ Drug Addiction	☐ ☐ Rheumatic Fever	☐ ☐ Parasites	☐ ☐ Autoimmune Disease
☐ ☐ Cancer	☐ ☐ Scarlet Fever	☐ ☐ Asthma	☐ ☐ Chicken Pox

Nervous System **P C**	**Eyes/Ears/Nose/Throat** **P C**	**Gastrointestinal** **P C**	**Musculoskeletal** **P C**
☐ ☐ Depression	☐ ☐ Vision Problems	☐ ☐ Change in Appetite	☐ ☐ Jaw Pain
☐ ☐ Memory Loss	☐ ☐ Flashing Lights	☐ ☐ Excessive Thirst	☐ ☐Difficulty Chewing
☐ ☐ Confusion	☐ ☐ Black Spots	☐ ☐ Frequent Nausea	☐ ☐ Face Pain
☐ ☐ Dizziness	☐ ☐ Blurriness	☐ ☐ Hemorrhoids	☐ ☐ Neck Pain
☐ ☐ Fainting	☐ ☐ Hearing Loss	☐ ☐ Black/Bloody Stools	☐ ☐ Arm/Elbow Pain
☐ ☐ Convulsions	☐ ☐ Ringing in Ears	☐ ☐ Digestive Problems	☐ ☐ Wrist/Hand Pain
☐ ☐ Weakness	☐ ☐ Swallowing	☐ ☐Abdominal Cramping	☐ ☐ Mid Back Pain
☐ ☐Poor Balance		☐ ☐Gas/Bloating	☐ ☐ Lower Back Pain
☐ ☐Twitches/Tremor		☐ ☐ Heartburn	☐ ☐Thigh/Knee Pain
☐ ☐ Cold/Tingling		☐ ☐ Weight Problems	☐ ☐Ankle/Foot Pain
☐ ☐Sleeping		☐ ☐ Gall Bladder Issues	☐ ☐ Difficulty Walking
☐ ☐ Headaches		☐ ☐ Liver Problems	☐ ☐ Leg/Arm Fatigue

Date of Last Physical: _____/_____/________

Physical Exam:	By whom?	Results:
Blood Work:	By whom?	Results:
Bone Density Study:	Results:	
Pelvic Exam:	Results:	
PSA Exam:	Results:	
Mammogram:	Results:	

Current Medications *Please use an additional page if necessary

☐ Prescription ☐ Over the Counter ☐ Herbals ☐ Vitamin/Mineral/Dietary ☐ Other ☐ None

Date Started	**Name of Medication**	**Dose**	**Date Stopped**	**Reason for Medication**

Family History

Mother:	Alive & Well, age____ Deceased age___from what?	Any health conditions?
Father:	Alive & Well, age____ Deceased age___from what?	Any health conditions?
Brother:	Alive & Well, age___ Deceased age____ from what?	Any health conditions?
Brother:	Alive & Well, age____Deceased age____from what?	Any health conditions?
Sister:	Alive & Well, age____Deceased age____from what?	Any health conditions?
Sister:	Alive & Well, age____Deceased age____from what?	Any health conditions?
Maternal Grandmother:	Alive & Well, age___ Deceased age____ from what?	Any health conditions?
Maternal Grandfather:	Alive & Well, age___ Deceased age____ from what?	Any health conditions?
Paternal Grandmother:	Alive & Well, age___Deceased age___ from what?	Any health conditions?
Paternal Grandfather:	Alive & Well, age___Deceased age_____from what?	Any health conditions?
Children:	Ages:	Any health conditions?

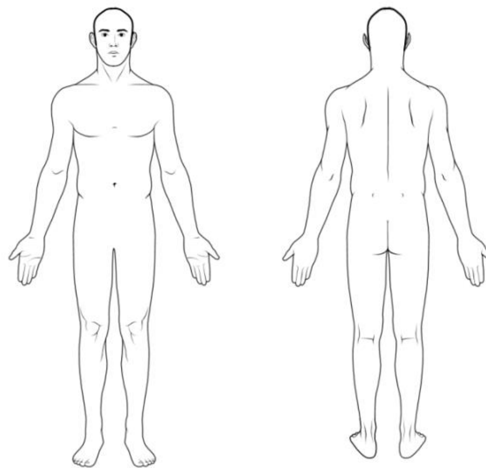
Have any of your family members ever suffered from any of the following conditions?

Diabetes	☐ Yes	☐ No	Type:
Heart Disease	☐ Yes	☐ No	Type:
Neurological Disorder	☐ Yes	☐ No	Type:
Depression/Mental Illness	☐ Yes	☐ No	Type:

Autoimmune Diseases	☐ Yes	☐ No	Type:
During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐ Yes	☐ No	
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No	

Pain/Discomfort

Use the body image diagram to mark the location of your primary pain complaint, as well as any additional pains/discomfort you are experiencing.



Pain Description (Please check all that apply):

☐ Deep	☐ Superficial	☐ Dull	☐ Sharp	☐ Burning	☐ Aching	☐ Knife-like
☐ Tingling	☐ Numbness	☐ Pins/Needles	☐ Throbbing	☐ Twitching	☐ Other:	---

Have you had previous episodes of this pain, if so when and how often:

On a scale of 0-10 where ‘0’ is no pain and ‘10’ is excruciating pain that requires going to the emergency room, please tell us where your pain rates:
Currently: ____
At worst: ____
At best: ____
What positions or activities make your pain better/worse?_____________________________________
____

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 hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- 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 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 (164.520). 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.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

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 are 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.

***Please list only the phone numbers that are acceptable for us to call in order to reach you.**

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

x____

PATIENT SIGNATURE **DATE**

Informed Consent for Chiropractic Care and Waiver to Treat

When a patient seeks chiropractic health care 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 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 of the spine) and function (primarily of the nervous system) as that relationship may have an effect on the restoration and preservation of health. Health is the 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 vertebra 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 and ***adjustment.*** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by hand held instruments. In addition, ancillary procedures such as adjustments of the extremities, physiotherapy and/or rehabilitative procedures may be included.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, muscle or ligament injuries, nerve injuries, vascular injuries such as stroke, dislocation and nerve injuries. I will make every reasonable effort during the consultation and examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Other treatment options include medications, surgery and alternative treatments. You should be aware that there are risks and benefits of those options which can be discussed with your primary medical physician. The risks associated with remaining untreated include but are not limited to the formation of adhesions and reduction of mobility which may set up a pain reaction further reducing mobility. Over time and the longer treatment is postponed, this process may complicate future care by making it more difficult and less effective. 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.

Do NOT Sign Until You Have Read and Understand the Above.

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 on this basis.

____

Patient Name **Signature** **Date**

Agreement for Payment of Services

1. Payment: Payment is required at the time of or prior to your date of service. **The obligation to pay for services may not be deferred for any reason.** Payment options include cash, check, Visa, MasterCard, American Express, and Discover. We also accept payment from Health Savings Accounts.

2. Cost of Service(s): The cost of service(s) varies based on the duration of your appointment. You will be held responsible for payment of these services at the time of or prior to the date of service.

3. Insurance and reimbursement:

   a) Horizon HealthWorks does not bill commercial insurance.
   b) Horizon HealthWorks is considered "out of network" by insurance providers.
   c) For your convenience and upon request, we will provide you with a receipt that includes your diagnosis codes and procedure costs and charges. This will allow you to submit your receipt to your insurance company to potentially seek reimbursement should you choose to do so.
   d) Each insurance company has different policies for claims submissions and reimbursement. It is your responsibility to determine the process involved in submission of claims and your insurance benefit information.

4. Missed Appointment(s): If you are unable to keep your scheduled initial exam appointment, we require 24 hours' notice to fill that time spot. If you no-show or do not notify us 24 hours in advance, you will be charged a $100 fee.

Initial ______ I acknowledge and agree that I will be personally responsible for all payments for Horizon HealthWorks services at the time of service.

Initial ______ I understand that Horizon HealthWorks is not familiar with my insurance policy, nor can they determine whether my insurance company will provide reimbursement for the services rendered, should I choose to submit claims myself.

I __________________________ hereby authorize, Horizon HealthWorks, to disclose all or part of the medical record of (patient's name) ___________________________ to any company that may be responsible for payment of all or part of this patient's medical charges. Disclosure of records may be necessary to determine eligibility for liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Horizon HealthWorks has already acted on my claim.

____

Patient Signature Date