

Northwest Health Solutions

Chiropractic Pain Management Spinal Decompression Massage Acupuncture Healthy Weight Loss

Jim Westerman, D.C., C.S.C.S.

PATIENT INFORMATION SHEET

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

Would you like to receive occasional office information through your email? (circle one) Yes No

DATE OF BIRTH: _____

EMPLOYER: _____ WORK PHONE: _____

_____ SINGLE _____ MARRIED _____ OTHER

SPOUSE NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

REFERRED BY: _____

IS THIS AN AUTO OR WORK RELATED INJURY? _____ YES _____ NO

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

WILL YOU CONSENT TO NW HEALTH SOLUTIONS COMMUNICATING WITH YOUR PCP REGARDING YOUR CONDITION, DIAGNOSIS AND ONGOING TREATMENT IN OUR OFFICE? _____ YES _____ NO

FROM TIME TO TIME INSURANCE COMPANIES CONTACT US REQUESTING COPIES OF ANY AND ALL RECORDS PERTAINING TO PATIENT TREATMENT. DO YOU GIVE NW HEALTH SOLUTIONS PERMISSION TO PHOTOCOPY YOUR RECORDS AND SEND THEM TO ANY REQUESTING INSURANCE CO. FOR THE PURPOSE OF ASSISTING NW HEALTH SOLUTIONS IN COLLECTING PAYMENT FROM ANY INSURANCE CO.? _____ YES _____ NO

Print Name _____ Signature _____ Date _____

~7225 N. Mona Lisa Road Suite 100A~Tucson, AZ 85741~520-498-0082~

Name : _____ www.northwesthealthsolutions.com

Northwest Health Solutions

Chiropractic Pain Management Spinal Decompression Massage Acupuncture Healthy Weight Loss

Jim Westerman, D.C., C.S.C.S.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

As required by the Privacy Regulations, Northwest Health Solutions may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office. **PLEASE CHECK ALL THAT APPLY AND LIST THEIR NAMES.**

Spouse: _____ Parent: _____ Grandparent: _____
 Sibling: _____ Children: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

Mailing Address

If appropriate, I authorize the staff of NW Health Solutions to contact me at the following address. **PLEASE CHECK ALL THAT APPLY**

Home address listed on the Patient Information Sheet Other: _____

Phone

If appropriate, I authorize the staff of NW Health Solutions to contact me and/or leave voice messages at the following telephone/cell phone numbers. **PLEASE CHECK ALL THAT APPLY.**

Home Phone listed on the Patient Information Sheet Cell Phone listed on the Patient Information Sheet

Work Phone listed on the Patient Information Sheet

Fax & E-Mail

If appropriate, authorize the staff of NW Health Solutions to contact me by fax at the following number:

Fax no.: _____

Email address listed on the Patient Information Sheet

Print Name _____ **Signature** _____ **Date** _____

~7225 N. Mona Lisa Road Suite 100A~Tucson, AZ 85741~520-498-0082~

Name : _____ **www.northwesthealthsolutions.com**

Northwest Health Solutions

Chiropractic Pain Management Spinal Decompression Massage Acupuncture Healthy Weight Loss

Jim Westerman, D.C., C.S.C.S.

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 any licensed doctor of chiropractic at **NW Health Solutions** who now or in the future work at this clinic. I have had an opportunity to discuss with the doctor(s) of chiropractic at **NW Health Solutions** or with other office of 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(s) of chiropractic to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the fact 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 procedure. 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.

Signature _____ Date _____

FINANCIAL POLICY

*AS AN ADDITIONAL COURTESY TO YOU, NW HEALTH SOLUTIONS WILL VERIFY YOUR INSURANCE BENEFITS AND BILL YOUR INSURANCE COMPANY FOR YOU. HOWEVER, YOUR CONTRACT WITH YOUR INSURANCE COMPANY IS AN AGREEMENT BETWEEN YOU AND THE INSURANCE COMPANY. THEREFORE, YOU ARE ULTIMATELY RESPONSIBLE FOR UNDERSTANDING YOUR INSURANCE BENEFITS AS WELL AS ANY AND ALL COMMUNICATION WITH YOUR INSURANCE COMPANY.

*YOU ARE ULTIMATELY RESPONSIBLE FOR ANY BALANCE ABOVE AND BEYOND YOUR CO-PAY AND WHAT YOUR INSURANCE COMPANY MIGHT PAY, AS DIRECTED ON THE EXPLANATION OF BENEFITS SENT OUT BY YOUR INSURANCE COMPANY.

*THERE ARE CERTAIN SERVICES/THERAPIES PROVIDED AT NW HEALTH SOLUTIONS THAT MAY BE RECOMMENDED IN YOUR TREATMENT PLAN THAT MAY NOT BE A COVERED BENEFIT UNDER YOUR INSURANCE. YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR THESE SERVICES.

*PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Signature _____ Date _____

~7225 N. Mona Lisa Road Suite 100A~Tucson, AZ 85741~520-498-0082~

Name : _____ www.northwesthealthsolutions.com

Northwest Health Solutions

Chiropractic Pain Management Spinal Decompression Massage Acupuncture Healthy Weight Loss

Jim Westerman, D.C., C.S.C.S.

<p><u>GENERAL</u></p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Sweats</p> <p><u>EYES</u></p> <p><input type="checkbox"/> Crossed eyes <input type="checkbox"/> Double Vision <input type="checkbox"/> Vision-Flashes <input type="checkbox"/> Vision-Halos <input type="checkbox"/> Blurred Vision</p> <p><u>EARS/NOSE/THROAT</u></p> <p><input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sinus Problem <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Persistent Cough</p> <p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Distress <input type="checkbox"/> Sputum</p> <p><u>GENITO-URINARY</u></p> <p><input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Breast changes</p>	<p><u>ENDOCRINE</u></p> <p><input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Hair changes</p> <p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting w/o blood <input type="checkbox"/> Vomiting w/ blood</p> <p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins</p> <p><u>INTEGUMENTARY</u></p> <p><input type="checkbox"/> Bruise Easy <input type="checkbox"/> Hives/ Scars <input type="checkbox"/> Change in moles <input type="checkbox"/> Sores that won't heal <input type="checkbox"/> Itching/ Rash <input type="checkbox"/> Unusual swelling <input type="checkbox"/> Sores/ulcers <input type="checkbox"/> Extreme thirst</p>	<p><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> Seizures <input type="checkbox"/> Loss of facial expression <input type="checkbox"/> Weak grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Difficulty with speech <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Numbness <input type="checkbox"/> Un-coordination <input type="checkbox"/> Sciatica <input type="checkbox"/> Arm pain</p> <p><u>MUSCULOSKELETAL</u></p> <p><input type="checkbox"/> Neck pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Low back pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Hand pain</p> <p><u>PSYCHIATRIC</u></p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Extreme Worry <input type="checkbox"/> Hallucinations <input type="checkbox"/> Irritable <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug addiction <input type="checkbox"/> Sexual problems <input type="checkbox"/> Suicidal thoughts</p> <p><u>CONDITIONS</u></p> <p><input type="checkbox"/> AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lumps</p>	<p><input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chicken pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate problems <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid issues <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Venereal disease <input type="checkbox"/> Other _____</p>
---	---	---	--

~7225 N. Mona Lisa Road Suite 100A~Tucson, AZ 85741~520-498-0082~

Name : _____

www.northwesthealthsolutions.com

Northwest Health Solutions

Chiropractic Pain Management Spinal Decompression Massage Acupuncture Healthy Weight Loss

Jim Westerman, D.C., C.S.C.S.

Past History None

- Angina Myocardial Infarction Congestive Heart Failure COPD Diabetes Stroke Appendectomy
 Hysterectomy Hernia Tonsillectomy
 Other: _____

Family History None Unknown

If applicable please indicate any family members (mother, father, grandparents, or siblings) who have any of the following. When marking cancer please indicate what type.

Type 1 Diabetes: _____
Type 2 Diabetes: _____
Cancer: _____
Heart Disease: _____
Stroke: _____
High Cholesterol: _____
Other: _____

Social History

Smoking: Don't Smoke Smoke: _____ Packs/Day _____ How Many Years

Are you actively trying to quit? Yes No

Alcohol: Don't Consume Alcohol Do Consume: _____ Drinks/Day _____ Drinks/Week Beer Wine Liquor

Exercise: No Yes Type: _____
How Often: _____

Do you currently follow any specific diet? No Yes If Yes, please describe: _____

Do you currently take any nutritional supplements? No Yes If Yes, please list all that you take: _____

Do you currently take any medications? No Yes If Yes, please list all medications: _____

~7225 N. Mona Lisa Road Suite 100A~Tucson, AZ 85741~520-498-0082~

Name : _____ www.northwesthealthsolutions.com