PATIENT INFORMATION

DATE:________________

NAME:______________________________ CELL PHONE #______________________

ADDRESS:______________________________ E-MAIL:______________________

CITY:______________________________ STATE:______________ ZIP______________

HOME PHONE:______________________________ WORK PHONE:______________________

AGE:__________ BIRTHDATE:______________ SOCIAL SECURITY #______________________

SEX: M F MINOR SINGLE MARRIED SEPARATED DIVORCED WIDOWED

YOUR EMPLOYER:____

OCCUPATION:______________________________ YEARS ON JOB:______________

ADDRESS:____

CITY:______________________________ STATE:______________ ZIP:______________

SPOUSE INFORMATION:

SPOUSE'S NAME:____

SPOUSE EMPLOYED BY:____

OCCUPATION:______________________________ YEARS ON JOB:______________

SPOUSE'S EMPLOYER'S ADDRESS:____

CITY:______________________________ STATE:______________ ZIP:______________

RESPONSIBLE PARTY:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:______________________________

RELATIONSHIP TO PATIENT:______________________________ PHONE :______________

ADDRESS:____

CITY:______________________________ STATE:______________ ZIP:______________

IN CASE OF AN EMERGENCY:

(Name of relative or close friend not living in your home)

NAME:______________________________ RELATIONSHIP TO YOU:______________

ADDRESS:______________________________ PHONE #______________

WHOM MAY WE THANK FOR REFERRING YOU?

NAME:______________________________ RELATIONSHIP TO YOU______________

PAYMENT INFORMATION:

PLEASE CIRCLE ONE PAYMENT TYPE:

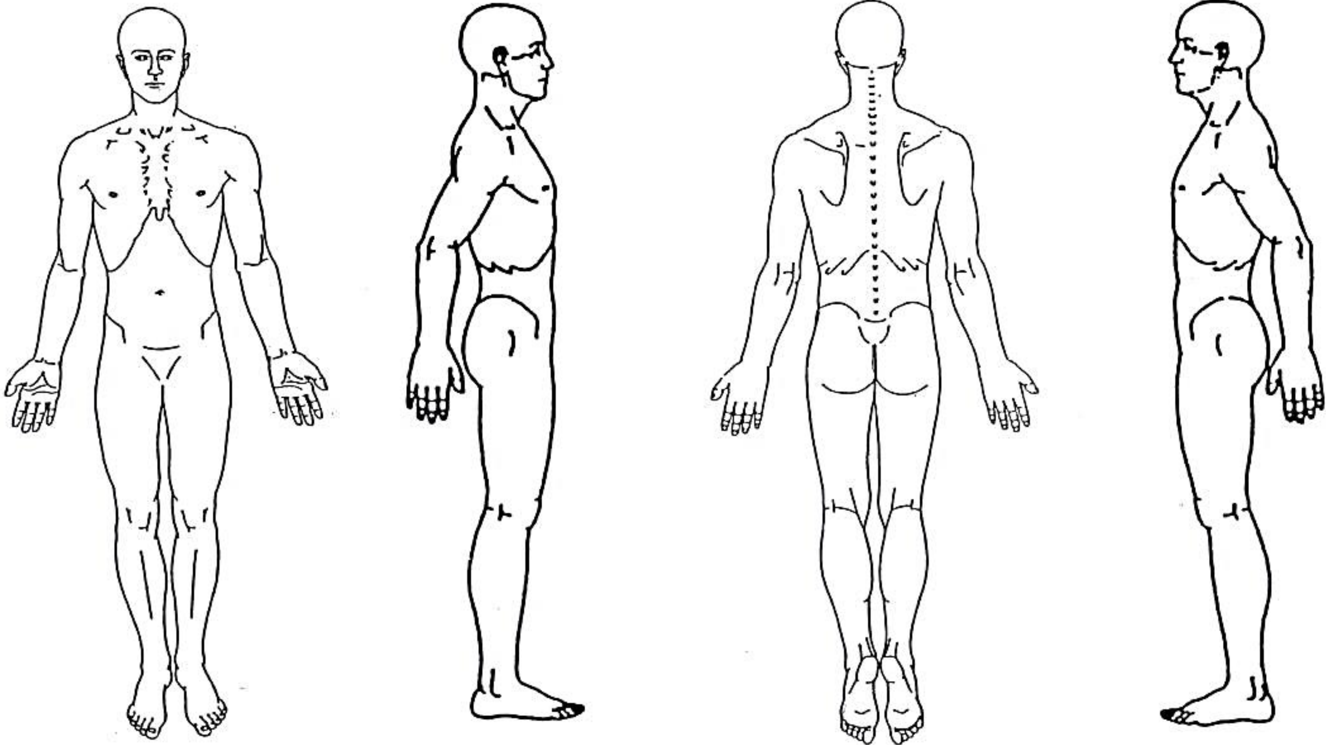
CASH CHECK MASTERCARD VISA DISCOVER

DO YOU HAVE INSURANCE? _________

DO YOU HAVE MEDICARE? __________

IF YOU WILL GIVE US YOUR INSURANCE CARD(s), WE WILL MAKE A COPY FOR YOUR FILE....

COMPLETE THESE DIAGRAM:
(PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAMS)



ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE: DULL, SHARP, CONSISTENT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

____

____

____

____

____

PLEASE LIST ANY CONDITIONS YOU ARE BEING TREATED FOR:

____

____

____

IS YOUR CONDITION DUE TO AN ACCIDENT? ___________ DATE OF ACCIDENT:____________________

TYPE OF ACCIDENT? AUTO _________ WORK/ON JOB_________ AT HOME_________ OTHER_____________

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? ___________

IF YES, WHEN? PAST YEAR________ PAST 5 YEARS_________OVER 5 YEARS_________NEVER_____________

WHAT IS YOUR MAJOR COMPLAINT?____________________

LIST ANY SURGICAL OPERATIONS AND YEARS:

HAVE YOU EVER HAD ANY MENTAL OR EMOTIONAL DISORDERS? YES______ NO______

IF YES, WHEN?____________________

HAVE ANY OTHERS IN YOUR FAMILY HAD SUCH DISORDERS? YES______ NO______

IF YES, WHEN?____________________

HAVE YOU EVER	***YES***	***NO***	***DESCRIBE BRIEFLY***
BEEN KNOCKED UNCONSCIOUS			
BEEN TREATED FOR A SPINE DISORDER?			
BEEN TREATED FOR A NERVE DISORDER?			
HAD A FRACTURED BONE?			
BEEN HOSPITALIZED FOR ANYTHING OTHER THAN SURGERY?			
DO YOU			
NOW TAKE VITAMINS OR MINERALS?			
THINK YOU NEED VITAMINS / MINERALS?			
HAVE AN ALLERGY TO ANY DRUG?			

DATE OF LAST:	***LESS THAN 6 MONTHS***	***6-18 MONTHS***	***OVER 18 MONTHS***	***NEVER***
SPINAL EXAMINATION				
PHYSICAL EXAMINATION				
BLOOD TEST				
CHEST X-RAY				
SPINAL X-RAY				
URINE TEST				

HABITS:	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL				
COFFEE				
TOBACCO				
DRUGS				
EXERCISE				
SLEEP				

PLEASE CIRCLE THE APPROPRIATE ANSWER FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. WE WANT ALL THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE. THIS IS A CONFIDENTIAL HISTORY REPORT.

O - OCCASIONAL **F - FREQUENT** **C - CONSTANT**

GENERAL

O F C Allergy
O F C Chills
O F C Convulsions
O F C Dizziness
O F C Fainting
O F C Fatigue
O F C Fever
O F C Headache
O F C Loss of sleep
O F C Loss of weight
O F C Nervousness
O F C Depression
O F C Neuralgia
O F C Numbness
O F C Sweats
O F C Tremors

MUSCLE & JOINT

O F C Arthritis
O F C Bursitis
O F C Foot trouble
O F C Hernia
O F C Low back pain
O F C Lumbago
O F C Neck pain
O F C Neck stiffness
O F C Pain between shoulders

PAIN/NUMBNESS IN:

O F C Shoulders
O F C Arms
O F C Elbows
O F C Hands
O F C Hips
O F C Legs
O F C Knees
O F C Feet
O F C Painful tail bone
O F C Poor posture
O F C Sciatica
O F C Spinal curvature
O F C Swollen joints

GASTRO-INTESTINAL

O F C Belching or gas
O F C Colitis
O F C Colon trouble
O F C Constipation
O F C Diarrhea
O F C Difficult digestion
O F C Distension of Abdomen
O F C Excessive hunger
O F C Gall bladder trouble
O F C Hemorrhoids
O F C Intestinal worms
O F C Jaundice
O F C Liver trouble
O F C Nausea
O F C Pain over stomach
O F C Poor appetite
O F C Vomiting
O F C Vomiting blood

EYES, EARS, NOSE AND THROAT

O F C Asthma
O F C Colds
O F C Crossed eyes
O F C Deafness
O F C Dental decay
O F C Earache
O F C Ear discharge
O F C Ear noises
O F C Enlarged glands
O F C Enlarged thyroid
O F C Eye pain
O F C Failing vision
O F C Far sightedness
O F C Gum trouble
O F C Hay fever
O F C Hoarseness
O F C Nasal obstruction
O F C Near sightedness
O F C Nosebleeds
O F C Sinus infection
O F C Sore throat
O F C Tonsillitis

CARDIO-VASCULAR

O F C Hardening of arteries
O F C High blood pressure
O F C Low blood pressure
O F C Pain over heart
O F C Poor circulation
O F C Rapid heart beat

RESPIRATORY

O F C Chest pains
O F C Chronic cough
O F C Difficult breathing
O F C Spitting up blood
O F C Spitting up phlegm
O F C Wheezing

SKIN

O F C Boils
O F C Bruise easily
O F C Dryness
O F C Hives / Allegy
O F C Itching
O F C Skin eruptions (rash)
O F C Varicose veins

GENITO-URINARY

O F C Bed-wetting
O F C Blood in urine
O F C Frequent urination
O F C Inability to control kidneys
O F C Kidney infection
O F C Kidney stones
O F C Painful urination
O F C Prostate trouble
O F C Pus in urine

FOR WOMEN ONLY

O F C Congested breasts
O F C Cramps
O F C Backaches
O F C Excessive menstrual flow
O F C Hot flashes
O F C Irregular cycles
O F C Menopausal symptoms
O F C Painful menstruation
O F C Vaginal discharge

ARE YOU PREGNANT?________________

NUMBER OF CHILDREN________________

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

_________ ALCOHOLISM
_________ ANEMIA
_________ APPENDICITIS
_________ ARTERIOSCLEROSIS
_________ ARTHRITIS
_________ CANCER
_________ CHOREA
_________ COLD SORES
_________ DIABETES
_________ DIPHTHERIA
_________ ECZEMA
_________ EMPHYSEMA
_________ EPILEPSY
_________ FEVER BLISTERS
_________ GOITER
_________ GOUT
_________ HEART DISEASE
_________ INFLUENZA
_________ LUMBAGO
_________ MALARIA
_________ MEASLES
_________ MISCARRIAGE
_________ MULTIPLE SCLEROSIS
_________ MUMPS
_________ PLEURISY
_________ PNEUMONIA
_________ POLIO
_________ RHEUMATIC FEVER
_________ SCARLET FEVER
_________ STROKE
_________ TUBERCULOSIS
_________ TYPHOID FEVER
_________ ULCERS
_________ VENEREAL DISEASE
_________ WHOOPING COUGH

DRUGS YOU NOW TAKE:

NERVE PILLS YES______ NO_______
PAIN KILLERS YES______ NO_______
MUSCLE RELAXERS YES______ NO_______
TRANQUILIZERS YES______ NO_______
BIRTH CONTROL PILLS YES______ NO_______
OTHERS_________________________________

AGE OF MATTRESS___________________________
COMFORTABLE______________________________
UNCOMFORTABLE____________________________
DO YOU USE A BED BOARD?__________________

ARE YOU WEARING?

HEEL LIFTS YES______ NO______
SOLE LIFTS YES______ NO______
INNER SOLES YES______ NO______
ARCH SUPPORTS YES______ NO______

ADDITIONAL INFORMATION:

____

____

____

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I AGREE TO PAY FOR SERVICES RENDERED TO THE ABOVE MENTIONED PATIENT AS THE CHARGE IS INCURRED. I UNDERSTAND AND AGREE THAT HEALTH INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ANY / ALL SERVICES COVERED OR NOT COVERED. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE(S) FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

____ _______________
PATIENT'S SIGNATURE *DATE*

____ _______________
GUARDIAN'S SIGNATURE *DATE*

*****FULL PAYMENT IS DUE AT THE END OF EACH VISIT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE*** THANK YOU**

Specific Brainstem Procedure
Henri J. Dalliès, D.C.
Arthur B. Plesa, D.C.

FINANCIAL POLICY

Thank you for choosing The Apple Valley Clinic to serve your needs. The following in an explanation of our financial policy that we ask all patients to read and sign prior to treatment so that we may better serve you.

Our main concern is that you receive the proper and optimal treatment needed to restore health. Therefore, if you have any questions about our financial policy, do not hesitate to ask.

MAJOR MEDICAL: As a 3rd party payer we are no longer able to bill insurance companies (with the exception of traditional Medicare). We will provide you with the information you need to file your claim on your own.

AUTO ACCIDENTS: Most health insurance policies DO NOT pay if your injuries are the result of an automobile accident. We will need all the information concerning the accident, including police reports, insurance of responsible party, claim number, adjuster's name, phone number and address. There is a **6 MONTH** grace period after you have been released in order for you to settle your claim. **After 6 months, we must receive payment whether your claim is settled or not.**

WORKMAN'S COMPENSATION: You must have an authorization from your employer stating that they are approving you to come to our office. If for any reason your claim is denied, you will be responsible for the balance.

MEDICARE: The patient is responsible for all charges. However, we will gladly file your claims with Medicare. Supplement information will be supplied on the Medicare form for automatic crossover, however, if Medicare does not automatically cross over to your supplement, it will be your responsibility to file. You may bring your Medicare Summary Notice in for us to copy and we will provide you with the necessary forms.

If you do not fall under any of the above categories, payment is due in full at the time of service unless arrangements are made in advance.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and the opportunity to serve you.

For your convenience, we accept VISA, MASTERCARD, DISCOVER, CARE CREDIT, CASH, AND CHECKS.

Effective as of January 1, 2017.

______________________________ __________________

Patient Signature/Parent or legal guardian if under 18 Date

$35.00 service charge for all returned checks.
Regular charge for missed appointments without a 24 hour notice.

1032-B GREENVILLE HIGHWAY (US 25 SOUTH) HENDERSONVILLE, NC 28792 PHONE: (828) 698 - 6677 FAX: (828) 698 - 1197
E-MAIL: THEAPPLEVALLEYCLINIC@GMAIL.COM

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient: ____

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( )	Age( )	SISTER(S) Age( )	Age( )	CHILDREN Age( )	Age( )	Age( )
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause:

____

____

"Specific Brain Stem Procedure"

1032- B Greenville Highway, Hendersonville, NC 28792

828-698-6677

To prepare for your appointment in our office, please avoid the following:

Nicotine (or vaping) – **2** hours before

Caffeine – **4** hours before

Pain Medication – **6** hours before

THANK YOU

for your cooperation....

we only want the

BEST for YOU!!!

We look forward to seeing you soon.

The Apple Valley Clinic of Chiropractic
1032-B Greenville Highway
Hendersonville, NC 28792

ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the chiropractic adjustment (manipulative treatment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or counsel.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: "72010–GY". The "72010" code is for an x-ray. The "-GY" means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

ALWAYS-COVERED SERVICES

A typical example of a Medicare COVERED service is when you are injured or you are in much pain due to a bad spinal condition. You should expect Medicare to pay for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your chiropractic adjustment, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

MY FINANCIAL RESPONSIBILITY

I have received the above information, "About Medicare Chiropractic Coverage." I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x ______________________________ ______________
Signature of patient or person acting on patient's behalf Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x ______________________________ ______________
Signature of patient or person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

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