LIGHTHOUSE MEDICAL CENTER

New Patient Form

In order to provide you with the best wellness care, please complete this form in its entirety. All information is strictly confidential. Our staff will need to photocopy your driver's license, insurance card, and a debit/credit card to keep on file for payments. Please print.

Patient Information

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Is it ok to text you regarding appointments? ☐ Yes ☐ No Is it ok to email you regarding appointments? ☐ Yes ☐ No

Your email will NOT be shared with any third parties, and is used for general office announcements and promotions. We won't spam you, promise!

Gender: ☐ Male ☐ Female Age: _____ Birth Date: _____ /_____ /_____ Number of Children: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Driver's License #: _____ Social Security #: _____

Employer: _____ Occupation: _____ Years at Current Employer: _____

How did you find out about us? ☐ Facebook ☐ Instagram ☐ Twitter ☐ Website ☐ Google/Web Search

☐ Referral (Name): _____ ☐ Other: _____

Account Information **PERSON RESPONSIBLE FOR THIS ACCOUNT.**

Name: _____ Relationship to Patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Driver's License #: _____ Social Security #: _____

Is your health insurance provided through your employer? ☐ Yes ☐ No

Insurance Company: _____ ID #: _____ Group #: _____

Name of Insured on Policy: _____ DOB of Insured: _____ /_____ /_____

Insured's Employer: _____ Occupation: _____ Years at Current Employer: _____

If on spouse or parent's policy

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **LIGHTHOUSE MEDICAL CENTER** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be rendered or provided***; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually) We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

I understand that outstanding balances of more than 30 days will be charged to this account. _____

Initials

Patient Signature: _____ Date: _____ /_____ /_____

Parent or Guardian Signature: _____ Date: _____ /_____ /_____

LIGHTHOUSE MEDICAL CENTER

Patient Health History

PLEASE COMPLETE ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

SOCIAL HISTORY

Age: _____ **Race:** ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other_____

Occupation:

Exercise? ☐ Yes ☐ No ☐ Occasionally ☐ Frequently ☐ Regularly

Tobacco? ☐ ☐ No If yes: ☐ Cigarettes ☐ ☐ Pipe ☐ ☐ Snuff ☐ Various

Alcohol? ☐ Yes ☐ No If yes: ☐ Socially ☐ Occasionally ☐ Frequently ☐ Regularly

FIRST COMPLAINT SYMPTOM DESCRIPTION

Describe your chief complaint: _____

On a scale of 0-10, with 0 being "You're pain free and can function quite well" and 10 being, "You're in pain all the time and cannot function at all, where would you rate yourself? Please fill in the blanks with a number below.

None - 0 Mild - 1 2 3 Moderate - 4 5 6 7 Severe - 8 9 10

Pain level at its: _____Current _____Worst _____Best

Does your pain radiate? ☐ Yes ☐ No **Location:** ☐ Arm ☐ Leg **Side:** ☐ Right ☐ Left ☐ Both

Type of pain (check all that apply):

☐ Achy ☐ Burning ☐ Dull ☐ Numb ☐ Sharp ☐ Shooting ☐ Sore ☐ Stiff ☐ Tingling

When did this condition first begin? _____

Is your pain: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Getting Worse ☐ Getting Better ☐ The Same

What caused this complaint? _____

_____

_____

SECOND COMPLAINT SYMPTOM DESCRIPTION

Describe your chief complaint: _____

_____

_____

On a scale of 0-10, with 0 being "You're pain free and can function quite well" and 10 being, "You're in pain all the time and cannot function at all, where would you rate yourself? Please fill in the blanks with a number below.

None - 0 Mild - 1 2 3 Moderate - 4 5 6 7 Severe - 8 9 10

OTHER SYMPTOMS

☐ Headache	☐ Neck Pain	☐ Neck Stiffness	☐ Shoulder Pain
☐ Upper Back Pain	☐ Mid Back Pain	☐ Low Back Pain	☐ Low Back Stiffness
☐ Hip/Pelvic Pain	☐ Arm/Wrist/Hand Pain	☐ Leg/Ankle/Foot Pain	☐ Numbness Leg/Foot
☐ Tingling Arm/Hand	☐ Tingling Leg/Foot	☐ Chest/Rib Pain	☐ Sacral Pain
☐ Knee Pain	☐ Elbow Pain	☐ TMJ	☐ Other_____

Symptoms Better/Worse (check all that apply):

Better with:	☐ Sitting	☐ Standing	☐ Lying Down	☐ Movement	☐ Walking	☐ Exercise
	☐ Work	☐ Normal Daily Activities	☐ Heat	☐ Ice	☐ Massage	☐ Stretching/Yoga
Worse with:	☐ Sitting	☐ Standing	☐ Lying Down	☐ Movement	☐ Walking	☐ Exercise
	☐ Work	☐ Normal Daily Activities	☐ Bending	☐ Twisting	☐ Lifting	

CONDITION HISTORY

Past History

☐ No past history of this condition

☐ Similar symptoms when ______________________________

Past Treatment: ☐ Manipulation ☐ Medication ☐ Surgery ☐ PT ☐ Other ______________________

☐ Same symptoms when ______________________________

Past Treatment: ☐ Manipulation ☐ Medication ☐ Surgery ☐ PT ☐ Other

Past Diagnostic Workup

☐ No past diagnostic workup

☐ Past procedures performed for this condition within the last year (check all that apply):

☐ MRI ☐ CT ☐ Scan ☐ NCV ☐ Bone Scan ☐ Blood Work ☐ Urine Test ☐ EMG

☐ Diagnostic Ultrasound ☐ Doppler Study Other

Past Treatments (Check all that apply and your response(s) to each)

☐ No Past Treatment

☐ Manipulation/Adjustment	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Massage Therapy	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Anti-Inflammatories	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Muscle Relaxers	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ RX Pain Medication	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Physical Therapy	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Surgery	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Exercise	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Bed Rest	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Ice/Heat	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief
☐ Other ______________	☐ Complete Relief	☐ Marginal Relief	☐ No Significant Relief	☐ Significant Relief

Past Doctors

Name: ______________________________ Approx. date of last visit: ______ /______ /______

Type of visit: ☐ Treatment ☐ Consultation

Type of doctor: ☐ Chiropractor ☐ Primary care ☐ Neurosurgeon ☐ Neurologist ☐ Orthopedic
☐ Physical Medicine ☐ ER Physician ☐ Physical Therapist ☐ Other ____________________

Name: ______________________________ Approx. date of last visit: ______ /______ /______

Type of visit: ☐ Treatment ☐ Consultation

Type of doctor: ☐ Chiropractor ☐ Primary care ☐ Neurosurgeon ☐ Neurologist ☐ Orthopedic
☐ Physical Medicine ☐ ER Physician ☐ Physical Therapist ☐ Other ____________________

Name: ______________________________ Approx. date of last visit: ______ /______ /______

Type of visit: ☐ Treatment ☐ Consultation

Type of doctor: ☐ Chiropractor ☐ Primary care ☐ Neurosurgeon ☐ Neurologist ☐ Orthopedic
☐ Physical Medicine ☐ ER Physician ☐ Physical Therapist ☐ Other ____________________

Any other symptoms you currently have (check all that apply):

☐ Cancer	☐ Kidney	☐ Uterine	☐ Hypertension	☐ Liver	☐ Prostate
☐ Heart	☐ Gall Bladder	☐ Neurological	☐ Lung	☐ Thyroid	☐ Seasonal Allergies
☐ Gastrointestinal	☐ Diabetes Mellitus	☐ Food Allergies	☐ Cholesterol	☐ Skin	☐ Autoimmune disease
☐ Eyes	☐ Ears	☐ Nose	☐ Throat	☐ Genitourinary	☐ Blood disorders
☐ Depression/anxiety	☐ Fatigue	☐ Weight gain	☐ Hormones	☐ Other ______________	

Provider notes / office use only

Family History (check all that apply):

☐ Respiratory Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Hypertension	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ GI/GU Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Diabetes Mellitus	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Skin Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Neurologic Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Arthritic Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Deaths in Family	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Spine Surgery	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Disc Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister

List all accidents (give dates and injuries, slips/falls, vehicle accidents, sports etc. from most recent to to oldest):

_____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, when and why? _____

_____

List all past surgeries with dates: _____

Are you taking Coumadin, Heparin, or other blood thinners? ☐ Yes ☐ No

List all medications, supplements/vitamins with dosage: _____

_____

List any allergies to medications/substances: _____

PATIENT HEALTH SURVEY

Have you ever at any time experienced any of the following? (check all that apply)

☐ Difficulty Urinating	☐ Loss of Bladder Control	☐ Loss of Bowel Control	☐ Temporary Loss of Vision
☐ Blood in Urine	☐ Claustrophobia (Fear of Small Spaces)	☐ Spinal Surgery	☐ Common Cold/Flu
☐ Carotid Artery Surgery	☐ Breast Removal	☐ Detached Retina	☐ Stroke
☐ Osteoarthritis	☐ Herniated Disc	☐ Osteoporosis	☐ TIA's (Pin or Mini Strokes)
☐ Drop Attacks (Collapsing, But Not Fainting)		☐ Hardening of the Arteries	☐ Partial or Complete Paralysis
☐ Rheumatoid Arthritis	☐ Fractured/Broken Vertebra	☐ Bleeding Disorders	☐ High Blood Pressure
☐ Blood in Stool	☐ Cancer ☐ HIV/AIDS	☐ Kidney Disease	☐ Prostate Disease

Do you currently have, or could you be, any of the following? (check all that apply)

☐ Heavy Smoker (1+ Packs/Day)	☐ Surgical/Medical Implanted Device	☐ Aortic Clips	☐ Brain Clips
☐ Artificial Heart Valves	☐ Rods, Pins, Screws	☐ IUD	☐ Surgical Clips/Wires
☐ Shunt	☐ Neurostimulator	☐ Dentures	☐ Pacemaker
☐ Hearing Aid	☐ Insulin Pump	☐ Joint Replacement	☐ Cochlear Implants (Ear)
☐ Pregnant	☐ Taking Birth Control Pills	☐ Tattoos	
☐ Receiving Chemotherapy	☐ Receiving Radiation Therapy	☐ Taking Blood Thinners	
☐ Bullets/Shrapnel	☐ Body Piercing	☐ Receiving Hormone Therapy (☐ Male ☐ Female)	
☐ Other Implanted Devices _____		☐ Metal Fragments (Head, Eye, Skin)	

In the past 14 days (2 weeks), have you experienced any of the following? (check all that apply)

☐ Nausea	☐ Vomiting	☐ Vertigo (Spinning)	☐ Difficulty Walking
☐ Incoordination	☐ Numbness or Sensory Complaints	☐ Loss of consciousness	☐ Double Vision
☐ Blurred Vision	☐ Tinnitus (Ringing in Ears)	☐ Speech Problems	☐ Clumsiness
☐ Memory Loss	☐ Travel by Car/Truck	☐ Personality Changes	☐ Fever
☐ Recurrent Headaches	☐ Diarrhea	☐ Used a Tanning Bed/Booth	☐ Skin Rash/Infection
☐ A Major Fall	☐ A Minor Fall	☐ An Auto Accident	☐ A Work Injury
☐ Loss of Strength	☐ Pain Moving Bowels	☐ Head Trauma	☐ Abnormal Period

Provider notes / office use only

LIGHTHOUSE MEDICAL CENTER

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the provider(s) has/have the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: _____ Date: _____ /_____ /_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ Date: _____ /_____ /_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20 _____

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent / Guardian (circle one)

LIGHTHOUSE
MEDICAL CENTER

Authorization for the Release of Protected Health Information (PHI)

Name of Patient: _____ Date of Birth: _____ /_____ /_____

I hereby request and authorize Lighthouse Medical Center, 1765 South 20th Avenue Safford, AZ 85546

☐ To disclose medical information to the following individual(s):
☐ To receive medical information from the following individual(s):

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

☐ To disclose medical information to the following physician(s) or entity(ies):

☐ To receive medical information from the following physician(s) or entity(ies):

Physican Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Physican Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Physican Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Information to be disclosed includes (check all that apply):

☐ Entire Patient Record
☐ Financial Information
☐ Treatment Plan Information
☐ Email Imaging to: _____
☐ Initial Exam Notes
☐ X-ray Reports/Film
☐ Daily Treatment Notes
☐ MRI Reports/Film

By signing this form, I authorize Lighthouse Medical Center to release confidential health information about me, by releasing a copy of my patient records, or a summary or narrative of my protected health information, to the person(s) or entity(ies) listed above. I understand that I have a right to revoke this authorization at any point in time by stating so in writing.

Signature of Patient: _____ Date: _____ /_____ /_____

If patient is a minor or under a guardianship order as defined by State law:

By_____ Date: _____ /_____ /_____
Signature of Parent / Guardian (circle one)

Staff Signature: _____ Date: _____ /_____ /_____

LIGHTHOUSE
MEDICAL CENTER

Consent to X-Ray

I hereby acknowledge that a healthcare provider and/or a staff member at Lighthouse Medical Center has informed me of the advisability of, risk inherent in, and the probable consequences of not receiving X-rays. He/She has also explained to me the reasons and need for such X-rays. I do hereby authorize any of the licensed healthcare providers to perform all such X-rays as are deemed pertinent to the diagnosis and management of my case.

Signature of Patient: _____ Date: _____ /_____ /_____

Staff Signature: _____ Date: _____ /_____ /_____

Pregnancy Waiver

TO BE COMPLETED BY ALL FEMALES OF CHILDBEARING AGE

I hereby acknowledge that a healthcare provider and/or a staff member at Lighthouse Medical Center has informed me prior to being X-rayed of the advisability of risk and the probable consequences of receiving X-rays during pregnancy. I have

stated on my own volition that I am not pregnant nor am I attempting to get pregnant as of this date and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Date: _____ /_____ /_____

_____
Patient Printed Name

_____
Patient Signature

Witness:

_____
Printed Name

_____
Signature

Informed Consent to Physical Medicine and Chiropractic Treatment

Name of Patient: _____

Lighthouse Medical Center

1765 South 20th Avenue Safford, AZ 85546 | 928-424-1600

DEAR PATIENT:

Welcome to Lighthouse Medical Center, PLLC. We are glad you chose our office to partner with you in relieving your pain and improving your quality of life. Our integrated, multi-specialty medical practice strives to provide exceptional care in every aspect of the patient experience, including communication. To that end, we want you to be aware that every type of healthcare is associated with some risk. We want you to be informed about important potential risk factors involving the various treatments/procedures performed in this office before consenting to treatment. This is called informed consent.

In this office, in addition to our licensed Family Nurse Practitioners (FNP-C), Doctors of Chiropractic (DC), and Massage Therapists (LMT), we use experienced, trained assistants who may assist the provider(s) with portions of your care. This includes but is not limited to: consultations, examinations, PT/rehab/exercise instruction, spinal decompression, injections, blood draws, medical procedures, etc. On the occasion when your attending provider is unavailable, your care may be handled by another provider or trained assistant.

GENERAL RISKS:

Soft Tissue Injury.

Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment/treatment or rehabilitation exercise/therapy may tear some muscle or ligament fibers. The result is a temporary increase in pain and soreness, but there are no long term effects for the patient. This process can be necessary with some patients to help achieve a resolution to your problem(s). These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns.

Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness.

It is common for chiropractic adjustments, spinal decompression, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your provider.

CHIROPRACTIC ADJUSTMENT RISKS:

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

The nature of the chiropractic adjustment.

Our doctors will use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains/separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and

without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Ancillary treatment.
In addition to chiropractic adjustments, the following additional treatments may be used: physical therapy and/or rehabilitation, massage therapy, medical weight loss, regenerative joint and trigger point injections, peripheral neuropathy treatment, allergy testing/treatments, bio-identical hormone therapy.

These treatments involve the following additional risks: infection, allergic reaction, scars, bleeding, pain at the site of injection, vasovagal reaction.

The availability and nature of other treatment options.
Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- Hospitalization with traction
- Surgery

The material risks inherent in such options and the probability of such risks occurring include.
Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is uncertain, and exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with a licensed healthcare provider and/or a staff member at Lighthouse Medical Center, PLLC and have had all questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ /_____ /_____

_____
Patient Printed Name

_____
Patient Signature

_____
Signature of Parent or Guardian (if a minor)

Witness:

_____ _____
Printed Name Signature

LIGHTHOUSE
MEDICAL CENTER

Financial Policy

Thank you for choosing Lighthouse Medical Center, PLLC as your healthcare provider. This office is committed to providing exceptional patient care and service. We politely request that you read and understand our policy regarding your responsibility for payment of professional services rendered to you by licensed providers of this office.

Patients Without Insurance
Payment for all services is due at the time the services are rendered, unless arrangements are made with our billing staff as part of a payment plan. We accept cash, Visa, Discover, MasterCard, American Express and Care Credit. We also accept HRA and/or FSA payments.

Patients With Health Insurance
We are an in-network provider for most major insurance plans. While not all insurance plans provide coverage for all medical, chiropractic and/or rehabilitation treatment, most do. We do accept assignment on MOST insurance plans. We do accept assignment on MVA (automobile accident claims. We do accept Letters of Protection from attorneys. We must have your insurance information verified prior to your first visit to do any insurance billing. In the event that your insurance company does not pay within 45 days, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us has been satisfied. Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan. All copays and deductibles are due at the time of treatment unless a payment plan is authorized.

Credit Card Guarantee / Electronic Debit Authorization
Our office utilizes a credit card guarantee to provide simplicity for both the patient and our billing staff in securing payment of outstanding balances. **ALL patients with ALL types of cases accepted by this office are required to have a valid credit card on file.** This card will only be billed for the following reasons:

1. Patient gives specific authorization to use this card in accordance with pre-arranged payment for professional services as part of ongoing treatment plan.
2. Upon notification of an outstanding balance, including missed appointment fees, if a patient refuses to make other arrangements with our billing staff, the card on file will be charged for all balances owed.

***If a patient does not wish to provide a credit card guarantee, this office will require payment up front for all services prescribed as part of the treatment plan, and it will be your responsibility to recoup payment from any third party payer (insurance). Patient Initials: _____**

Treatment Financing Options
Our office works hard to make sure the care you need is affordable for you. We do provide the following financing options: Care Credit and weekly payments. This will be explained in detail to you after your treatment plan has been prescribed and explained by the doctor.

Missed Appointment Policy
Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. While emergencies happen periodically, we ask that you contact us by phone at 928-424-1600 in the event you won't be able to make your appointment. This will enable us to offer your appointment time to other patients that desire to get their treatment performed that day/time. Our policy is to charge $50.00 for missed (no-show chiropractic appointments and $65.00 for massage appointments. **Patient Initials: _____**

Practice Fee Schedule
Our practice is committed to providing the highest quality treatment available to our patients. We charge a fee for all services provided that is "usual and customary" for our geographic area. While we are a participating provider for various insurance networks, and we do take contractual write-offs where appropriate, please remember that you remain responsible for payment regardless of any insurance company's arbitrary determination for usual and customary rates.

Minor Patients
Parents or legal guardians are required to accompany minor patients to the initial exam and explanation of treatment appointments. They are also required to give informed consent prior to any treatment being performed. Once treatment commences, parents/legal guardians retain full financial responsibility for all services performed.

Assignment of Benefits
I do hereby assign all medical and/or chiropractic benefits to Lighthouse Medical Center, PLLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I authorize Lighthouse Medical Center, PLLC to release all information necessary to secure payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. By my signature below, I acknowledge that I have read and agree to the aforementioned financial policy for Lighthouse Medical Center, PLLC.

Signature of Patient / Parent / Legal Guardian: _____ Date: _____ /_____ /_____

Staff Signature / Witness: _____ Date: _____ /_____ /_____