Avenues Health Center

Alton J. Krenzelok, D.C.
Tyler J. Tonso, D.C.
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Patient Information

Date: _____

Name: _____ **E:Mail** _____
(Last) (First) (Middle)

Address: _____ **City** _____ **St.** _____ **Zip** _____

Home # _____ **Work #** _____ **Place of Work** _____ **Cell#** _____
Cell Provider: _____

Sex (M) ___ **(F)** ___ **Married** ___ **Single** ___ **Birth Date** ___/___/_____ **SSN:** _____-_____-_____

Who may we thank for referring you to our office? _____

Emergency Contact

Name: _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Insurance Information

Insurance Company: _____ **Policy Holder's Name:** _____ **Birth Date** ___/___/___

I authorize the release of any medical or other information necessary to process all claims made to my current insurance company. I also request payment of government benefits to the party who accepts assignment below. I authorize payment of medical benefits to Avenues Health Center as described on the health insurance claim form.

SIGN HERE _____ **Date** _____

Office Policies

Payment Policy: Payment is expected at the time of visit, whether you have insurance or not. Once we know that your insurance deductible is met and what your insurance company is going to pay, we require the co- payment each visit. We can secure your account with a valid credit card that we can charge each co-payment to. Payment of the percent (%) not covered by insurance, after deductible has been met, will be due and payable at the time of service. Any balance left after insurance payment is received will be due and payable from you. If we have not received payment from your insurance company at the end of **45** days, the balance will become your responsibility. We offer a cash discount, please ask if you are interested in this discount.

Cancellation Policy: A $25 fee will be charged for missed appointments. ***Please initial here*** _____

I authorize the release of any medical or other information necessary to process insurance claims submitted on the behalf of myself or my dependents.

By signing here I certify that I understand and agree to be held accountable to the above policies.

Patient's Signature _____

Notice: Patients under the age of 18 must have consent from a legal guardian.

_____

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Patient Name: _____ **DOB:** _____

HEALTH HISTORY

Circle Any Conditions You Have Had or Currently Have:

Anemia	Epilepsy	Malaria	Pacemaker	Stroke
Cancer	Gout	Measles	Pleurisy	Tuberculosis
Blood Disorder	Heart Attack	Multiple Sclerosis	Pneumonia	Ulcers
Diabetes	Influenza	Mumps	Polio	Whooping Cough

Are you currently pregnant? Yes No Weeks:_____

Serious Illnesses/Injuries/Hospitalizations:	**Year**	**Current Treatments**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Surgeries:

Type _____	Year:_____	Resolved: Y N
Type_____	Year:_____	Resolved: Y N
Type _____	Year:_____	Resolved: Y N
Type _____	Year:_____	Resolved: Y N

X-rays/CT/MRI's: _____

Medications and/or Supplements you are currently taking:	**Reason**
If you do not have enough room, please bring a list with you during the next visit so we can make a copy.	
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Family Health History: Diabetes Cancer HBP High Cholesterol Heart Disease Disc herniations

Other: _____

Have you seen a chiropractor before? ☐ Yes ☐ No

If yes, how long ago?_____ For what reason? _____ Did it help? Y N

History was obtained from: Patient Spouse Father Mother Other:_____

Patient/Guardian Signature:_____ Date:_____

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date