WEST MICHIGAN CHIROPRACTIC CENTER
DR. CHRIS HAWKINS D.C.

WEST MICHIGAN CHROPRACTIC CENTER, P.L.C.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy for Protected Health Information and Consent for Use or Disclosure of Health Information, currently in use by West Michigan Chiropractic Center, P.L.C. This authorization will expire seven years after the date on which you last received services from us. This notice is effective as of 12/31/02.

_____ _____

Patient Name Printed Date

_____

Patient Signature

_____

Personal Representative Printed

_____

Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

WEST MICHIGAN CHIROPRACTIC CENTER, P.L.C.

6475 BELDING RD NE, ROCKFORD, MI 49341

Treatment Consent and Payment Agreement

In consideration for the services rendered to me by West Michigan Chiropractic Center, PLC (WMCC), I hereby execute this Treatment Consent and Payment Agreement ("Agreement") and agree to the following:

CONSENT FOR TREATMENT: knowing that I desire (or the patient for whom I am signing desires) chiropractic treatment from WMCC, I do hereby voluntarily consent to such treatment by West Michigan Chiropractic staff and employees as deemed necessary in their judgment to my chiropractic care and understand the risk when accepting care which can include, but is not limited to, musculoskeletal injury, stroke, or arterial dissection.

NO REPRESENTATIONS OR GUARANTEES: I am aware that the chiropractic treatment is not an exact science and I acknowledge that no oral or written representations, guarantees or promises have been made to me as to the results of any treatment and care that I (or patient) may receive from WMCC. I am aware that compliance with any treatment program designed by WMCC is essential to my (or the patient's) successful treatment. I understand that additional treatments may be necessary if I (or the patient) do not adhere to the prescribed treatment schedule, fail to cooperate in treatment, fail to follow exercise recommendations, or engage in activity outlined to be injurious or which causes additional trauma to the body.

RELEASE OF INFORMATION: I hereby authorize WMCC to release any information about my treatment or physical condition to any person involved in my medical or chiropractic care and any third party responsible for paying for my care, including, without limitation, records relative to claims, my employer, and any workers compensation insurance carrier engaged by my employer and to any outside peer review or auditing agency engaged in third party payer to review my medical records. WMCC may also give information to Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any other third party who may be responsible for payment of my account. WMCC may release my chiropractic records to any collection agency or attorneys it has engaged to collect any amounts due for services it has provided to me and I agree that those collection agencies or attorneys may introduce my chiropractic records as necessary in any court action to collect any amounts due for effect as long as is necessary to effectuate the purposes for which it is given.

ASSIGNMENT OF INSURANCE BENEFITS: I assign to WMCC all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for WMCC's services. I also give WMCC the right to intervene in any lawsuit or other action brought by me, or on my behalf, to collect amounts due to WMCC for services rendered to me. If I have (or the patient for whom I am signing has) insurance through Michigan Blue Cross/Blue Shield, Medicare, Medicaid, OCHAMPUS, or any third party, or an automobile no fault carrier, I agree that I want WMCC to bill my insurance directly and request that any payment for insurance be made directly to WMCC. I certify that the insurance information given by me is correct. I understand that I am responsible for any balance not paid by insurance.

PAYMENT AND GUARANTY AGREEMENT: I agree to the following:

a) In consideration for the services to be rendered by WMCC to the Patient and the Patient's representative or agent shall both be personally obligated to pay for such services in accordance with WMCC's standard rates, irrespective of whether the undersigned signs as Patient or the Patient's representative or agent. Either the Patient or the Patient's representative or agent must pay all the amounts not paid by Insurance.
b) Payment is due in full after WMCC deposits in the mail the first bill to the Patient or the Patient's representative or agent. If the outstanding bill is not paid within 30 days after mailing the first bill, the account will be considered delinquent and a late payment charge of 0.5% per month (6% per annum) will be added to the unpaid balance 30 days after the first billing and every 30 days thereafter.
c) In the event that the account is turned over to an attorney or collection agency for collection, the Patient or the Patients representative or agent shall pay all reasonable collection costs including attorney fees incurred by WMCC.
d) The signature of the Patient's representative or agent does not relieve the Patient from his or her obligation to pay for services rendered.
e) In consideration for payments that have been paid in advance for treatments not yet received, that WMCC will refund such payments within (30) thirty days of written notice from the Patient or the Patient's representative or agent.

MISCELLANEOUS: Where "I" is used in this agreement, it refers to both the Patient and the Patient's representative or agent. I understand that WMCC has no duty to investigate the authority of the Patient's representative or agent and is relying on the representation of the Patient's representative or agent that he or she has the authority required to enter into this agreement.

MASSAGE: Cancelation policy: In the event that you cancel with less than 24 hours from the time of your massage appointment and/ if you do not attend your massage without notice, there will be a charge for half of the cost of your massage. If you arrive late for your massage, the amount of time for your massage will be decreased proportionately based on what time your arrived.

I UNDERSTAND THAT ANY AMOUNTS NOT PAID BY MY INSURANCE ARE MY RESPONSIBILITY.

By signing below, I acknowledge that I have read, understand and agree to the terms of this West Michigan Chiropractic Center, PLC Treatment Consent and Payment Agreement.

_____ _____

Printed Patient Name Relationship (if other than Patient) Date

_____ _____

Signature of Patient or Patient's representative or agent Signature of West Michigan Chiropractic Center staff

West Michigan Chiropractic Center, P L.C.

Patient Information (please print or circle information as needed)

Today's Date: ___/____/___

Name: _____ Phone: (____) _____
First MI Last

Preferred name: _____

Address: _____ City_____ State____ Zip_____

Male Female **Date of Birth: ___/____/____**

Patient Soc Sec #: _____

Marital Status: Single Married Widowed Separated Divorced Cohabitating

Spouse/ Partner Name: _____

First MI Last

Spouse/ Partner Date of Birth: ____/_____/_____

Spouse/ Partner Cell number: (____) _____
"I authorize West Michigan Chiropractic, to release patient health information (PHI) to my spouse listed above. This includes diagnoses, treatment options, appointments, treatments and test results".
X_____

Emergency Contact Name: _____ Same as above: _____

Relationship: _____ Home/Cell: (___) _____
"I authorize West Michigan Chiropractic, to release patient health information (PHI) to my emergency contact listed above. This includes diagnoses, treatment options, appointments, treatments, and test results".
X_____

Children: Yes No **If yes, how many? _____** **Ages: _____**

Email: _____ **I would like my statements emailed to me:** Yes No

Occupation: _____ **Work activity:** sitting standing combination

Whom may we thank for referring you? _____

Insurance
Would you like us to bill your insurance? Yes No

Signature on file
I authorize use of this form on **all** my insurance submissions. I authorize release of information to all my **Insurance Companies.** I understand that **I am responsible** for my bill. I authorize Dr. Chris Hawkins to act as **my** agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to West Michigan Chiropractic Center, P.L.C. I permit a copy of this authorization to be used in place of the original.

Printed Name: _____ **Signature: _____**

Current Medical History: *(Please fully complete questionnaire to the best of your knowledge)*

What is the primary concern which brings you to the office? _____
_____

Did symptom appear: Suddenly Gradually **If sudden, date of onset**:_____
If gradually, how long? Days weeks months or years

Is this condition due to an injury? Yes No **If yes, what type of injury?** Auto Work Home Other

How often does it bother you? Everyday 2-3 times per week few times a month rarely

What symptoms do you experience? Circle or List ie: shooting, stiffness, aching, burning, nausea, anxiety, etc
_____

What activities or movements increase your pain symptoms? Circle or List ie: bending, climbing stairs, concentrating, driving a car, lifting, looking over shoulder, rising out of a chair/ bed, walking, lying down etc
_____

What have you found makes it better? _____

Habits: ___smoking packs/ day___ How long have you smoked? _____
___chewing tobacco cans/ day____ How long have you chewed? _____
___Water intake cups/ day____
___alcohol intake drinks/wk____
___high stress reason_____
___exercise times/wk____

Have you had: Please check all that apply

( ) Aneurysm	**( ) Tuberculosis**	**( ) Osteoporosis**
( ) Angia	**( ) Multiple Sclerosis**	**( ) Parkinson's**
( ) Heart attack	**( ) Cancer**	**( ) Alzheimer's**
( ) TIA	**( ) HIV/ AIDS**	**( ) Hemophilia**
( ) Stroke	**( ) Hepatitis A B C D E F**	**( ) Atherosclerosis**
( ) PAD	**( ) Rheumatoid Arthritis**	**( ) Ulcer/ Acid reflux**
( ) Diabetes	**( ) High Blood Pressure**	**( ) Depression/ Anxiety**

System Review:

Cardiac	**( )None**	**( )Shortness of breath**	**( )Chest pain**	**( )Fainting spells**	**( )arrhythmia**
Pulmonary	**( )None**	**( )Productive cough**	**( )Wheezing**	**( )Bloody cough**	**( )Asthma**
Constitution	**( )None**	**( )Fever**	**( )Unexplained weight loss**		
G-I	**( ) None**	**( )Rectal bleeding**	**( )Loss of bowel control**	**( )Constipation**	**( )Diarrhea**
G-U	**( )None**	**( )Bloody urine**	**( )Increased Frequency**	**( )Loss of bladder control**	
Intracranial	**( )None**	**( )Memory loss**	**( )Vision changes**	**( )Dizzy**	**( )Confused**
Integument	**( )None**	**( )Skin Rash**	**( )Bruising**	**( )Mole changes; itch, bleed, shape**	

Broken bones or dislocations (fractures):_____
Car accident: Yes No **If yes, when?** _____
Were you ever knocked unconscious: Yes No **If yes, why?** _____
Have you ever seen a chiropractor before: Yes No **If yes, when?** _____

Medical History continued

Are there any other conditions not listed that you would like the doctor to be aware of?

_____

_____

Average hours of sleep per night: _____ **How many pillows do you use? 0 1 2 3 4**
(Under your head/ neck)

Mattress Type: ( ) Traditional ( ) Air bed ( ) Memory Foam ( ) Water bed

Do you currently wear orthotics (shoe inserts)? Yes No **If yes, custom made or over the counter? _____**

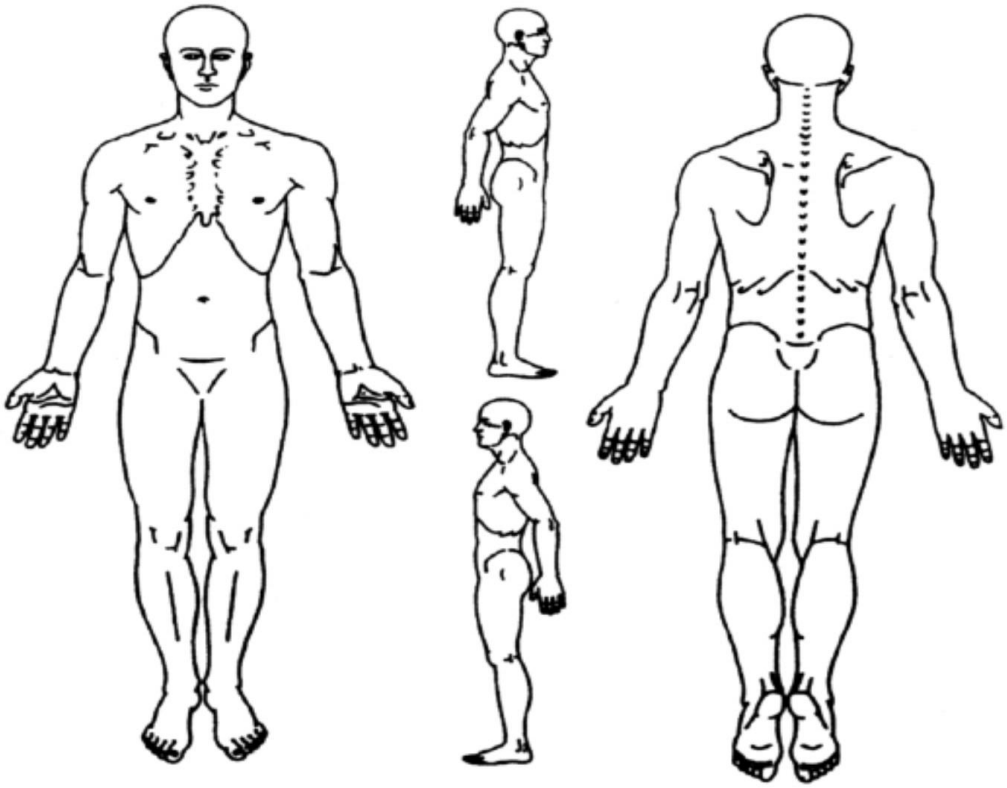
Please list any pertinent surgeries: ie: back, neck, hip, knee etc

1._____Date:_____
2._____Date:_____
3._____Date:_____

Medication List: (*Please include prescriptions, over the counter, vitamin supplements and herbs. If needed, use the back of this form to write an additional list)*

Medication	Dose	Reason
1.		
2.		
3.		
4.		
5.		

On the diagram below, please indicate where you are experiencing pain right now. Please mark the exact locations using the following abbreviations: **P = Pain T = Tingling N = Numbness B = Burning S = Stiffness**



Circle the severity of your pain on the scale of 1-10 with 10 being extreme pain.

1 2 3 4 5 6 7 8 9 10