LoCoco CHIROPRACTIC

Date: _____

Patient Information & History

Patient Information

Name: _____
(First) (Initial) (Last)

Address: _____

_____
(City) (State) (Zip)

Birthday: ____/____/____ Age: ____ Male: ___ Female: ___

Social Security Number: _____ - _____ - _____

Occupation: _____

Employer: _____

Parent's Name (if a minor): _____

Single: ___ Separated: ___ Divorced: ___ Widowed: ___

Married: ___ Spouse's Name: _____

Number of Children: _____

Contact Information

Home Phone: ( ) _____ - _____

Cell Number: ( ) _____ - _____

Work Phone: ( ) _____ - _____

Email: _____

Voicemail Permission: ___ yes ___ no

Best Way to Reach You: ___ Home ___ Cell

In Case of Emergency, Contact:

I.C.E Name: _____

Relationship: _____

Home Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____

Accident Information

Is Your Condition Due to an Accident? Yes: ___ No: ___

Type of Accident: Automobile: ___ Work: ___ Home: ___

Other: ___ Explain: _____

Date of Accident: _____ / _____ / _____

To Who Have You Reported This Accident?

Insurance: ___ Worker's Comp: ___ Employer: ___

Other: ___ Explain: _____

Insurance

Who is Responsible for this account?

Name: _____

Insurance Company: _____

Insurance ID Number: _____

Group / Claim Number: _____

Additional Insurance Information (Secondary)

Insurance Company: _____

Insurance ID Number: _____

Please Continue on the Next Page...

Patient Condition

What Is Your Major Symptom / Problem? _____ Date Symptom Begun: ___/___/___

Have You Had This Problem Before? Yes ___ No ___ If yes explain: _____

***Is Your Condition Getting Progressively Worse*? Yes ___ No ____ *Is This Problem:* Constant ___ Comes and Goes ___**

How Does It Feel? Burning___ Sharp ___ Shooting___ Dull___

Aching___ Stiff___ Tingling___ Throbbing____ Swelling___ Other___ Explain: _____

Circle the Severity of Your Pain on a Scale of 0 to 10: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

What Makes Your Condition Better? **_____ *What Makes It Worse?*** **_____**

Does Your Condition Interfere With Your: Work___ Sleep___ Daily Routine___ Recreation___

Activities / Movements that are Painful to Perform: Sitting___ Standing___ Walking___ Bending___ Lying Down___

Driving___ Reading___ Getting Up___ Other___ Explain: _____

Health History

What Other Treatments Have You Had for This Condition? Chiropractic___ Orthopedic___ Neurologist___ Medication___

Physical Therapy___ Surgery___ Other___ Explain: _____ Previous Chiropractic Care? Yes___ No___

Name of Other Doctors Who Have Treated You for This Condition _____

Date of Last: **Physical Exam_____ Spinal X-Ray _____ MRI_____ Spinal Exam_____ CT-Scan_____**

List ANY Medications you are taking: _____

List ANY Vitamins, Minerals or Herbs you are taking: _____

Females: Are You Pregnant? Yes___ No___ Beginning of Last Menstrual Cycle: _____

Check any of the following conditions YOU have had:

AIDS/HIV___
Allergies _____
Anxiety/Depression ___
Arm/Shoulder Pain ___
Arthritis ____
Asthma _____
Bladder Problems ___
Cancer ____
Chronic Fatigue ____
Deafness ____
Diabetes ____
Digestion Problems ____
Earache ____
Ear Ringing ___
Epilepsy ____
Headaches ____
Heart Disease ____
Hemorrhoids ____
Herniated Disk ____
High Blood Pressure _
Insomnia ___
Irregular Cycle ____
Kidney Problems ____
Leg Pain ___
Migraines ___
Neck Pain ___
Osteoporosis ___
Poor Circulation ___
Prostate Problems ___
Rheumatoid Arthritis ___
Sciatica ___
Shingles ___
Sinus Infection ___
Stroke ___
Thyroid Problems ___
TMJ ___
Urinary/Bladder Incontinence ____
Bowel Incontinence ___
Venereal Disease ___
Vertigo/Dizziness ___

Please continue on the following page…

*Stressors: Please check and number (*Smoking___ / Packs a Day___) (Alcohol___ / Drinks in a Week___) (Coffee___ / Cups a Day___) (High Level Stress___ / Reason: _____.)

Exercise: None___ Moderate___ Daily___ Heavy____

Have you had any:

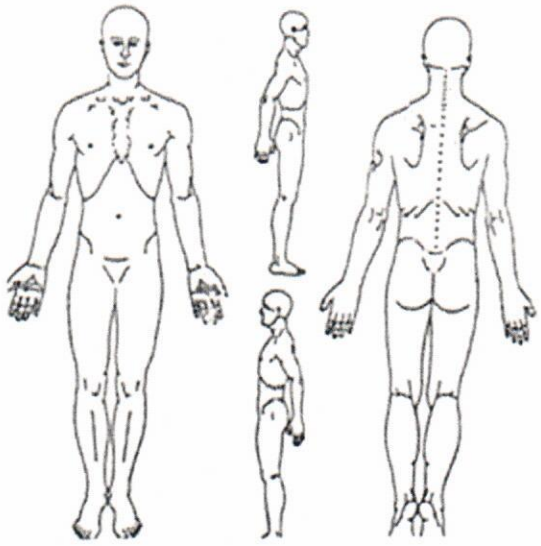
Surgeries_____ Date: _____

Broken Bones_____ Date: _____

Falls/Head Injuries_____ Date: _____

Automobile Accidents_____ Date: _____

Please mark where it hurts



Authorization

Insurance verification and authorization is **not** ***a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize LoCoco Health and Wellness, Inc, Nicholas A. LoCoco, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.***

_____ _____ _____

Patient Signature *Date* *Parent (if patient is a minor)*

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date_____

Please read carefully

Instructions: Please circle the numbers that best describes the questions being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

1- What is your pain RIGHT NOW?

No pain _____ worst pain

0 1 2 3 4 5 6 7 8 9 10

2- What is your TYPICAL or AVERAGE pain?

No pain _____ worst pain

0 1 2 3 4 5 6 7 8 9 10

3- What is your pain level AT ITS WORST (how close does your pain level get to a "10"?

No pain _____ worst pain

0 1 2 3 4 5 6 7 8 9 10

4- What is your pain level AT ITS BEST?

No pain _____ worst pain

0 1 2 3 4 5 6 7 8 9 10

New Injury Form

Patient Name: _____ Date: ___/___/_____

Pain Scale: Please circle the number that best describes your pain

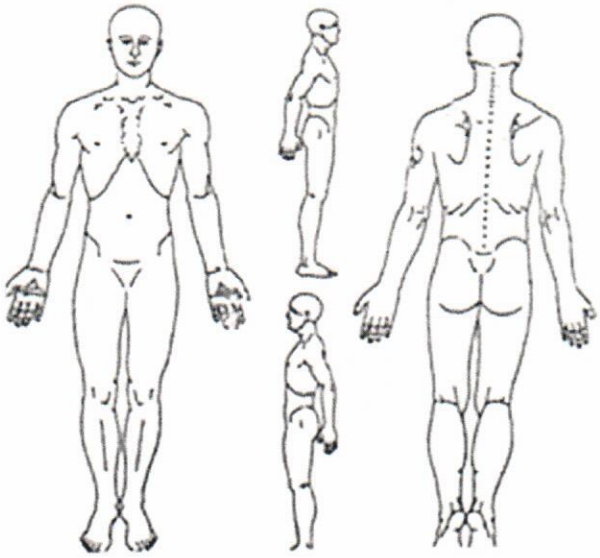
None - 0 1 2 3 4 5 6 7 8 9 10 – Severe

Pain Questionnaire

- When did your injury / accident occur? _____
- When did your pain begin? _____
- What makes your condition better? _____
- What makes your condition worse? _____
- Does your pain travel down your arms and legs? If yes, explain _____

  _____
- Is your pain constant or occasional? _____
- Did you experience any of these symptoms prior to your injury or accident? Yes or No

Explain _____



Place an **"X"** on the drawing below on **ALL** areas causing you pain. Use the guide below to explain these symptoms. Place a letter next to the "X."

A= Ache

B= Burning

S= Stabbing

N= Numbness

P= Pins & Needles

Patient Signature: _____

CHIROPRACTIC DISCOVERY & WELLNESS XRAY CONSENT FORM

Patient name: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

PLEASE CHOOSE ONE:

_____ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such test.

_____ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of any and all liabilities.

Signature: _____ Date: _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken it is possible to injure the fetus.

I have been advised that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising the doctor that:

I am pregnant	____yes	____no	____ don't know
I could be pregnant	____yes	____no	____don't know
My menstrual period is late	____yes	____no	
I have an IUD	____yes	____no	
I have had tubal ligation	____yes	____no	
I have had a hysterectomy	____yes	____no	
I have irregular menstrual periods	____yes	____no	
My last menstrual period began	_____		
I have begun menopause	____yes	____no	
Have you completed menopause	____yes	____no	____don't know

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders by:
Mail _____;
Email_____; at email address
_____;
Telephone numbers_____;
_____;
By voice mail _____;

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

LoCoco Health and Wellness, Inc., LLC
CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by LoCoco Health and Wellness, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of LoCoco Health and Wellness, Inc.. I understand that diagnosis or treatment of me by LoCoco Health and Wellness, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. LoCoco Health and Wellness, Inc. is not required to agree to the restrictions that I may request. However, if LoCoco Health and Wellness, Inc. agrees to a restriction that I request, the restriction is binding on LoCoco Health and Wellness, Inc., as well as Nicholas A. LoCoco, D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that LoCoco Health and Wellness, Inc., Nicholas A. LoCoco, D.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review LoCoco Health and Wellness, Inc.' Notice of Privacy Practices prior to signing this document. The LoCoco Health and Wellness, Inc.' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of LoCoco Health and Wellness, Inc.. The Notice of Privacy Practices for LoCoco Health and Wellness, Inc. is also provided in the patient waiting area. This Notice of Privacy Practices also describes my rights and LoCoco Health and Wellness, Inc.' duties with respect to my protected health information.

LoCoco Health and Wellness, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. You may designate an individual to be your personal representative below. This person shall be given all of the privileges that would belong to you regarding your health information. Your designation can be revoked at any time by signing a revocation and delivering it to LoCoco Health and Wellness, Inc.. However, any revocation will not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on your previous designation.

_____
Name of Patient (please print)

_____
Name of Designated Personal Representative

_____
Signature of Patient

_____
Relationship of Personal Representative to you

_____
Date

REVOCATION SECTION: I hereby revoke my designation of a personal representative.

_____
Name of Patient (please print)

_____
Signature of Patient

_____
Date

LoCoco Health & Wellness, Inc.
4242 Popps Ferry Road * D'Iberville, Mississippi

Financial Policy

Thank you for choosing LoCoco Health & Wellness, Inc as your healthcare provider. We are committed to providing the best medical care possible. The following statement explains our Financial Policy, which we ask you to read and sign prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to all appointments.
- All applicable co-pays, deductibles, coinsurance amounts, and personal balances (both current and prior) are due at the time of service. Amounts collected are estimates only.

Regarding Insurance - LoCoco Health & Wellness, Inc participate in the following health plans:

As a courtesy, we will bill your insurance company for the services provided to you. It is your responsibility, however, to know the benefits and conditions of your insurance plan. Some procedures require pre-certification or an authorization before the service is performed and we expect you to be aware of these situations and you should insure that pre-certification is obtained prior to your services. If for some reason your insurance company fails to pay, we will expect you to pay the balance in full. If we are contracted with your insurance company, we will charge you only the amount allowed by your insurance. We cannot submit claims to your insurance company without a copy of your insurance card and are not responsible for insurance denials for services rendered if you do not provide the correct insurance information. Your insurance policy is a contract between you and your insurance company. If we do not have a contract with your insurance company (see list above) and they have not paid the claim within 60 days, the balance of your account will be billed to you. If payment is not received within 60 days after the account has been billed to you, your account will be considered due in full and placed for collection. Please be aware that some services provided may be "non-covered" services and/or not considered reasonable and necessary under your plan.

Usual and Customary Payment - We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. Our fees are not negotiable and we will not accept "reasonable and customary" payments as payment in full. You will be responsible for any remaining balance.

Missed Appointments - Unless canceled at least 24 hours in advance, our policy is to charge $25 for a missed appointment. Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance so it will be your responsibility.

Past Due Accounts - All patient balanced greater than 60 days past due will accrue finance charges at 18% APR. This finance charge can be reduced by participating in a pre-arranged payment plan. Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Returned Checks - A fee of $25 will be charged for all checks returned to us as unpaid by your bank. In addition, no future payments by check will be accepted from you.

Refunds - Patient refunds for any amount over $5.00 will be processed monthly. Any amounts under $5.00 can be requested by the patient and picked up at our office.

This date I have contracted with LoCoco Health & Wellness, Inc. Unless I have received approval to be treated under a workers compensation claim, I will be responsible for payment of the total bill incurred as the result of treatment received (Medicare patients will be responsible for their portion of the Medicare allowable). I understand that the filing of insurance forms does not constitute payment of any portion of the bill and I understand that I am responsible for all charges billed me for treatment of the above patient unless this visit has been approved as a Workers Compensation claim. I have read and understand the Financial Policy of LoCoco Health & Wellness, Inc and agree to the terms set forth in this policy.

Print Name	Signature	Date