Dr. Aaron T. Halle • Chiropractic Physician
1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

Welcome to our office! *Thank you for choosing us as your chiropractic provider. Please complete the following information.*

PATIENT INFORMATION

I am a/an: ☐ New patient ☐ Existing patient/providing updated information

Legal name: _____ SSN: _____ Preferred name: _____

Birth date: _____ Age: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

Are you: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Prefer not to indicate

Health complaints/reasons for consulting this office: _____

Is this due to a: ☐ Work-related injury ☐ Vehicle accident/injury

Whom may we thank for referring you? _____

Please indicate whom we could contact in case of an emergency:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

FINANCIAL INFORMATION

Legal name of person responsible for this account: _____ Relationship to patient: _____

SSN: _____ ☐ Male ☐ Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Legal name of insured: _____ Relationship to patient: _____

Insured's birth date: _____ SSN or Member ID No.: _____ Group No.: _____

Insurance company: _____ Insurance phone: _____

Insured's employer: _____ Work phone: _____

Employer address: _____ City, State, Zip: _____

Please indicate any secondary insurance you have: _____ Please tell me more about this ☐ Yes ☐ No

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian (hereafter "I"), ever have a change in health, insurance, and or benefits. By signing this form, I certify I have insurance coverage with the above-named insurance company(ies), authorize the use of my signature on all insurance submissions, and assign directly to Halle Chiropractic, LLC. all insurance benefits payable for services rendered. I also hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical condition(s), accident(s), injury(ies), illness(es), past or future condition, to pay directly to and exclusively in the name of Halle Chiropractic LLC, such sums as may be owing for charges incurred by me for any and all service(s) rendered. Whether or not reimbursed by any or all of these entities, I understand that I am financially responsible for all charges.

Halle Chiropractic, LLC. may use my healthcare information and may disclose such information to the above-referenced payers and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

_____ _____

Signature of patient, parent, or legal representative/guardian Date

_____ _____

Printed name of patient, parent, or legal representative/guardian Relationship to patient

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PATIENT HEALTH HISTORY

Patient name (please print):_____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD AND HOW OFTEN IT OCCURRED:

OCCASIONAL	FREQUENT	CONSTANT	MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Carpal tunnel
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature (scoliosis)
☐	☐	☐	Swollen joints

OCCASIONAL	FREQUENT	CONSTANT	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia (nerve pain)
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
☐	☐	☐	Weight loss

OCCASIONAL	FREQUENT	CONSTANT	WOMEN
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge
			Pregnant? ☐ Yes ☐ No

OCCASIONAL	FREQUENT	CONSTANT	EYES, EARS, NOSE, & THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Farsighted
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Nearsighted
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

OCCASIONAL	FREQUENT	CONSTANT	GASTROINTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

OCCASIONAL	FREQUENT	CONSTANT	CARDIOVASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

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PATIENT HEALTH HISTORY (*continued*)

Occasional	Frequent	Constant	Genitourinary
☐	☐	☐	Bed wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

Occasional	Frequent	Constant	Respiratory
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing
Occasional	**Frequent**	**Constant**	**Skin**
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism	☐ Chorea	☐ Epilepsy	☐ Malaria	☐ Pleurisy	☐ Thyroid
☐ Anemia	☐ Cold sores	☐ Fever blisters	☐ Measles	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Diabetes	☐ Gout	☐ Miscarriage(s)	☐ Polio	☐ Typhoid fever
☐ Arteriosclerosis	☐ Diphtheria	☐ Heart disease	☐ Multiple sclerosis	☐ Rheumatic fever	☐ Ulcers
☐ Arthritis	☐ Eczema	☐ HIV/AIDS	☐ Mumps	☐ Scarlet fever	☐ Venereal disease
☐ Cancer	☐ Emphysema	☐ Influenza	☐ Parkinson's	☐ Stroke	☐ Whooping cough

☐ Other, please list:

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever had previous chiropractic care? ☐ Yes ☐ No If yes, date of last care and doctor name or location:_____

What is your major complaint? _____

Other complaints?_____

How long have you had these complaints?_____ Have you had these or similar complaints in the past? ☐ Yes ☐ No

What activities aggravate your complaints? ☐ Coughing ☐ Sneezing ☐ Reaching ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking

☐ Other, please describe:_____

Are these complaints getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Are these complaints interfering with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Other, please describe_____

Are your complaints the result of an ☐ On the job accident ☐ Auto accident ☐ Other, please describe_____

Was the accident within: ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Briefly describe your accident:_____

Please list previous diagnoses and treatments you've received for these complaints:_____

_____

How long has it been since you've felt good?_____ What do you believe is wrong?_____

Please list surgical operations and years:_____

Please list drugs you currently take:_____

Age of mattress:_____ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? ☐ Yes ☐ No

Age of pillow:_____ ☐ Comfortable ☐ Uncomfortable Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports (orthotics)

HAVE YOU EVER:

Been knocked unconscious? ☐ Yes ☐ No Describe:_____

Used a crane, crutch, or other support? ☐ Yes ☐ No Describe:_____

Been treated for a spine or nerve disorder? ☐ Yes ☐ No Describe:_____

Had a fractured bone? ☐ Yes ☐ No Describe:_____

Been hospitalized for other than surgery? ☐ Yes ☐ No Describe:_____

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PATIENT HEALTH HISTORY (*continued*)

DO YOU:

Now take vitamins or minerals? ☐ Yes ☐ No Describe:_____
Think you may need vitamins or minerals? ☐ Yes ☐ No Describe:_____
Have an allergy to any drug? ☐ Yes ☐ No Describe:_____

APPROXIMATE 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	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	**Heavy**	**Moderate**	**Light**	**None**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

List below all conditions for which you have been treated in the past 10 years:

_____
_____
_____
_____
_____
_____

FAMILY HEALTH INFORMATION – Many health problems are the result of hereditary spinal weakness; therefore, information about your family members will give the doctor a better understanding of your current health status.

Relation:_____ Past health problems:_____ Present health problems: _____
Relation:_____ Past health problems:_____ Present health problems: _____
Relation:_____ Past health problems:_____ Present health problems: _____

_____ _____
Signature of patient, parent, or legal representative/guardian Date

_____ _____
Printed name of patient, parent, or legal representative/guardian Relationship to patient

Halle Chiropractic, LLC

1857 N. Kolb
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

Date:_____

To:_____

_____

_____

I hereby authorize the release of my x-rays and/or copies of all records and request that they are transferred to:

_____

C/O Halle
1857 N. Kolb Rd.
Tucson, AZ 85715
(520) 290-2229
(520) 290-2236 fax

_____

Patient Name (please print)

_____

Patient Signature

DOB:_____

SS#_____

Halle Chiropractic, LLC
Aaron T. Halle, DC

HIPAA Compliant Patient Authorization

This authorization is requested in order to meet federal and state privacy guidelines. By signing you give the doctor and staff permission to use your personal information and health information for areas outlined below. This information is being requested so that we can better meet your health care needs. However, should you decline to authorize any of the items listed, it will not affect the treatment that we provide to you. You may also put certain limitations on the use of your information. This must be done in writing. You are not required to sign this form, but rather are only requested to do so.

You have the right to inspect your records at any time. You also have the right to change the authorizations previously given at any time. All requests must be in writing. Please allow a reasonable time for our clinic to carry out your request.

Copies of all of the documents we ask you to sign, read and agree to are kept in a book in our lobby. These forms are available to view at any time.

Your personal information will never be given to any group or individual for purposes of advertising or referrals outside of this clinic. It will only be used by our staff and only regarding your healthcare.

Please complete the following:

May we contact you on your home phone and leave a message? ○ **YES** ○ **NO**
Home phone number: _____

May we contact you on your cell phone and leave a message? ○ **YES** ○ **NO**
Cell phone number: _____

May we contact you at your work and leave a message if you are not there: ○ **YES** ○ **NO**
Work phone number: _____

Please email me with Special or Holiday hours and office news. ○ **YES** ○ **NO**
Email address, PRINT CLEARLY: _____

May we send a "Thank you" to the person(s) that referred you to our office? ○ **YES** ○ **NO**

May we discuss your medical condition and account information with any member of your family?
○ **YES** ○ **NO**

If yes, please name the members allowed:
_____

I authorize the staff and Dr. Halle at Halle Chiropractic, LLC to use my personal and health information as outlined above and in the Notice of Privacy Practices already disclosed to me.

_____ _____ _____
Print (patient name) **Signature (patient, parent or guardian)** **Date**

_____
Witness Signature

rev. 01/01/2019

Halle CHIROPRACTIC LLC

Dr. Aaron T. Halle • Chiropractic Physician
1857 N. Kolb Road • Tucson, AZ 85715 • PH: 520-290-2229 • FX: 520-290-2236

INFORMED CONSENT

Patient name (please print):_____

I hereby request and provide consent for Halle Chiropractic LLC (Dr. Halle) to perform chiropractic manipulation and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me or on the patient named below, for whom I am the parent or am legally responsible.

I understand that chiropractic manipulation is a specific adjustment for subluxation, that is, a joint that has lost its ability to move and function properly. Abnormal movement patterns and improper function will continue and may negatively impact nerve activity unless corrected. In order to correct this, I understand that Dr. Halle will use his hands or the necessary instruments to move joints within the affected area. The movement of joints can create an audible "pop" or "click." This is caused by gasses within the joint being released when it is adjusted.

I understand and am informed that, as in the practice of medicine, there are some risks to treatment in the practice of chiropractic. These risks can include but are not limited to fractures, disk injuries, dislocations, and sprains. These are rare and can result from an underlying weakness in or illness associated with the bones. Another risk is stroke; however, the chances for stroke are far rarer. A scientific study stated there is a 1 in 5.58 million chance for a stroke to be caused by a chiropractic adjustment (Haldeman et al, 1999). Despite the rarity of these risks, we conduct examinations and tests to identify if you may be susceptible to an injury or if an existing injury exists that would lead to health complications.

Other chiropractic procedures involve physiotherapy such as electrical muscle stimulation, traction, decompression, ultrasound, infrasound, application of cold and/or hot packs, exercises, stretching protocols, gait modification, and/or balancing. I understand these procedures may result in muscle strain, muscle spasms, ligament sprain, burns, dizziness, and other symptoms.

I do not expect Dr. Halle to be able to anticipate and explain all risks and complications. I wish to rely upon Dr. Halle to exercise judgment during the course of the procedure(s) which he feels at the time is/are in my best interest. I understand that Dr. Halle's judgment is based upon the facts known to him professionally as well as those that I have personally disclosed to him. I understand the importance of disclosing all medical information to Dr. Halle so I can be treated appropriately. I will notify Dr. Halle immediately to explain any negative symptoms so a necessary evaluation may be performed and corrective actions may be employed.

I have had an opportunity to discuss the nature and purpose of chiropractic manipulation and other procedures with Dr. Halle. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions and have had my questions answered satisfactorily. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. By signing below, I state that I have weighed the risks involved with recommended treatment and have decided it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to undergo the recommended treatment.

Signature of patient, parent, or legal representative/guardian	Date
Printed name of patient, parent, or legal representative/guardian	Relationship to patient

Halle Chiropractic, LLC

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Heart Rate _____

Financial Policy Summary

Dr. Aaron T. Halle, DC/ Halle Chiropractic, LLC

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- Self-Pay patients (patients that are uninsured or underinsured) may choose a pre-payment plan or "prompt payment" discount plan.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of **January 1, 2019** our office will be unable to extend any type of discounts other than those listed above.

**Personal checks returned for unsufficient funds will be subject to the charges imposed on our office by the financial institution.*
**Any outstanding balance over 60 days may be charged interest at one-and-one-half percent (1.5%) per month.*
**Any outstanding balance over 90 days may be subject to collection by an outside agency. You will be responsible for paying your outstanding balance, the accrued monthly interest, all collection fees, and any other fees incurred as a result of the collection effort.*

~~~~~~

I understand and agree to the following:

- **I have read or had read to me, the policies and procedures of Halle Chiropractic, LLC. I understand that these policies and procedures are not intended to be all inclusive. By signing below, I agree to comply with stated or implied policies and procedures.**
- **I have read or been given a copy of the Notice of Privacy Practices and understand that any questions may be directed to clinic Management.**
- **The doctor(s), employees, or designated agents of this clinic may use my protected health information in the manner described in the Notice of Privacy Practices.**

Patient signature:_____Date:_____
Patient Name (print):_____
~~~~~~