CORNERSTONE
CHIROPRACTIC CENTER

Patient Information

Name_____ Date _____

Address_____ City_____State____ Zip Code_____

Phone _____ Email Address _____

Social Security _____ Date of Birth _____ Status: S M D W

Current Employer _____ Telephone Number _____

Employment Status: Part Time Full Time Other

Who referred you to our clinic? _____

Primary Physician _____ Telephone Number _____

Do we have permission to contact your primary physician about your care here? Yes No

Emergency Contact Name _____ Number _____

Health Insurance Information:

Primary Insurance: _____ID# _____Grp# _____

Secondary Insurance: _____ID# _____Grp# _____

Primary's Name and Date of Birth _____

We will also need a copy of your current insurance card(s)

Auto/Worker's Compensation Insurance Company: _____

Date of Accident: _____ Claim Number:_____

Contact Person and Phone Number: _____

I have provided all the necessary billing information to Cornerstone Chiropractic Center to ensure prompt payment and by signing this I am agreeing to update Cornerstone Chiropractic Center immediately of any changes regarding the above information.

Patient/Guardian Signature: _____ Date: _____

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Patient Information

Name _____ Date _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed the problem? _____

   How did it originally occur? _____

   Has it become worse recently? Yes No Same Better Gradually Worse

   Explain _____

   How would you rate your pain? 1 2 3 4 5 6 7 8 9 10 (with 10 being the worst)
4. How frequent is the condition? Constant Daily Intermittent Night Only

   How long does it last? All Day Few Hours Minutes

   When is it worse? Morning Evening As the Day Progresses No Change
5. Are there any other conditions or symptoms that may be related to your major symptoms?

   Explain _____

   a) Are there any other unrelated health problems? Yes No

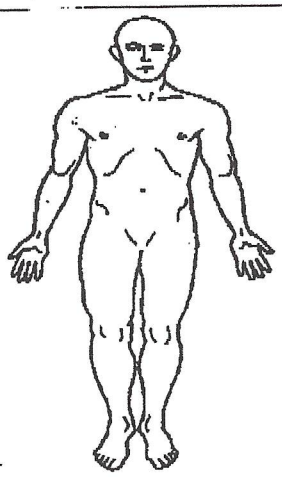
      Explain _____
6. Describe the pain: *Sharp *Dull *Numbness * Tingling *Aching *Burning *Stabbing

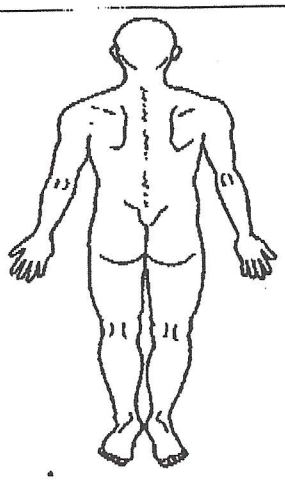
   *Other: _____
7. Is there anything you can do to relive the problem? Yes No Explain _____

   _____
8. What makes the problem worse? *Standing *Sitting *Lying *Bending *Lifting *Twisting

   *Other _____
9. List any major accidents you have had other than those that might have been mentioned:

   _____





Please show me where your symptoms are and the type of problems you are having using the following guide:

>>>	Pain
- - -	Pins and Needles
///	Burning
000	Throbbing
^^^	Sore
###	Aching

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Patient Information

Name _____ Date _____

Personal Health History
List any medical problems that other doctors have diagnosed:
☐ Hypertension ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Kidney Disease ☐ Neuropathy ☐ Stroke ☐ Brain Tumor ☐ Epilepsy ☐ Depression ☐ Dementia ☐ Anemia ☐ Arthritis ☐ Chronic Back Pain ☐ Other:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name of the Drug	Strength	Frequency Taken

Allergies to Medications:

Name of the Drug	Reaction You Had

Surgeries/Hospitalizations

Year	Reason	Hospital
Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	

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Patient Information

Name _____ Date _____

Past Tests:	☐ Angiocath ☐ Cardio Echo ☐ CT scan ☐ Blood Work ☐ Cultures ☐ Ultrasound ☐ MRI ☐ Biopsies ☐ X-rays ☐ NCV ☐ EMG
Date of last Physical Exam:	

Family Health History

Relative	Age	Cause of Death/Health Problems	Relative	Age	Cause of Death/Health Problems
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F		Grandmother (Maternal)		
	☐ M ☐ F		Grandfather (Maternal)		
	☐ M ☐ F		Grandmother (Paternal)		
	☐ M ☐ F		Grandfather (Paternal)		

Social History

Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
Household	☐ Live Alone ☐ With Spouse ☐ With _____
Alcohol	☐ None ☐ Casual (<5/week) ☐ Moderate (5-10/week) ☐ Heavy (>10/week)
Caffeine	☐ <3 drinks/day ☐ 3-6 drinks/day ☐ >6 drinks/day
Tobacco	☐ Never ☐ Casual Smoker ☐ Current Smoker ☐ Former Smoker ☐ Chewing Tobacco
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No
	Have you used recreational or street drugs in the past? ☐ Yes ☐ No
Exercise	☐ None ☐ Daily ☐ Weekly ☐ Walks ☐ Runs ☐ Swims
Occupation	☐ Student ☐ Employed ☐ Unemployed ☐ Retired Occupation: _____

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Name_____ Date _____

Review of Systems

Have you recently suffered from any of the following symptoms?

General	Weight Change Fatigue Fever Chills Weakness
Head	Headache – Location _____ Frequency _____
	Trauma to Head
Eyes	Blurriness Tearing Recent Vision Loss
Ears	Hearing Loss Ringing in the ears Vertigo/Dizziness
Respiratory	Shortness of Breath Cough Wheezing
Cardiac	High Blood Pressure Murmurs Palpitations Chest Pain
GI	Nausea Vomiting Abdominal Pain Diarrhea Blood in Stool
Vascular	Swelling in Legs Leg Cramps Leg pain with walking
MS	Muscle Weakness Muscle Pain Problems Balancing Joint Pain Gout
Neuro	Numbness Tingling Fainting Seizures
Endocrine	Increased Thirst Increased Urination Thyroid Problems Diabetes
Psych	Depression Anxiety High Stress Memory Loss

Pregnancy Waiver

I hereby acknowledge that Dr. Derek Scholl, , PO LLC of Cornerstone Chiropractic 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 violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____ _____

Signature of Patient/Authorized Representative of Patient Date

PATIENT CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

Clinic Treatment(s)

This document is a binding agreement (the "Agreement") between Cornerstone Chiropractic Center, PC,LLO, and/or (We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and by signing in the space provided):

1. **Consent for Treatment.** You hereby consent to and authorize Us to provide You with health care treatment, including without limitation medical, diagnostic, nutritional treatment, Intravenous Micronutrient Therapy, Prolotherapy and Prolozone (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

2. **Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of experimental procedures and methods, including without limit Intravenous Micronutrient Therapy, Prolotherapy, Trigger Point Therapy and Mesotherapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address or decrease your pain, symptoms or complaints, but also may have no effect.

3. **Risks, Side Effects, Complication.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation infection; swelling; increased pain; bleeding; scarring; scar or wound enlargement; keloid formation; asymmetry; temporary or permanent alteration in sensation; allergic reaction; discoloration; the need for additional surgery; soreness, itching, infection, injury to nerves, internally and externally leaking fluid and scaring at injection sites (all of which except the leaking fluid may be permanent); a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments; spinal cord injuries, Pneumothorax (air on the outside of the lung), paralysis, dizziness, numbness, no benefit from Treatments; or other serious or debilitating injuries or death.

4. **Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to you when we actually administer the Treatments.

5. **Health Care Staff.** You are aware that among those who attend you on our behalf are medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedure and Treatments.

6. **Information You Provide Us.** You have provided Us with a Complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies you may have, and all allergic or adverse reactions you have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to- date to the best of Your knowledge.

7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any question about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.

8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action.

9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between you and us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on you and your successors, heirs,

legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state of federal court in Pocatello, Idaho, and You submit to the jurisdiction of any such court.

Patient signature:_____ **Date:** _____

Cornerstone Chiropractic Center

2295 S. 48th St.

Lincoln, NE 68506

Payment Policy and Billing Procedures

1. Unless 100% of coverage has been verified with no copay, you are responsible for the copay per visit and/or deductible not covered by your insurance company. This payment is required at the time of each visit.
2. Your verified copay amount is $_____ per visit. Your coinsurance amount is ____% per visit. Your deductible amount is $_____ per visit, until your deductible has been met. This payment is due in full at the time of your visits.
3. We accept cash, check, or Visa, MasterCard, and Discover bank cards.
4. There will be a $25.00 charge for all returned checks.
5. We will send out statement for any balance on your account 30, 60, and 90 days after claim has been processed. If we have not received any payment(this may include setting up a reasonable payment plan) we will send your account balance to collections, and we will no longer be able to serve you.

Insurance Information

It is important to inform us of any changes or updates in your insurance coverage. Failing to do this may effect timely filing, in which you would be responsible for the full amount of your visit(s).

As a courtesy to our patients, we will verify and file your claim(s) with your insurance company; however, we connot guarantee payment. We strongly suggest that you read your policy manual as it pertains to chiropractic and/or physical therapy coverage. Many insurance companies have stipulations that limit the benefit in some way, such as sessions, supplies, deductibles, copay, etc. These stipulations should be noted in your policy manual.

Supplies/Medical Records Policy

SUPPLIES: Payment for all supplies not covered by insurance is due at the time of service.

MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible for payment of all supplies used in your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment.

WORKER'S COMPENSATION benefits will be verified; however, this does not guarantee payment. We may file with your insurance, until Worker's Compensation pays on account. IF Worker's Compensation denies payment, the balance will be your responsibility.

MEDICAL RECORDS: Medical records will be provided within 30 days after the date of your request. If you require Medical records prior to 30 days, you will be billed a $40.00 convenience charge due at time of request.

CONSENT TO TREATMENT

I UNDERSTAND THAT I HAVE SOUGHT OUTPATIENT TREATMENT AT Cornerstone Chiropractic Center, P.C., L.L.O., and that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician or by Cornerstone Chiropractic Center, P.C., L.L.O. provide treatment and care as prescribed.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of Cornerstone Chiropractic. I hereby authorize Cornerstone Chiropractic Center to furnish my insurance company(s), attorney, or legal representative all information which said parties might request concerning my present illness or injury. I hereby assign Cornerstone Chiropractic Center, P.C., L.L.O. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible to Cornerstone Chiropractic Center, P.C., L.L.O for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

PATIENT NAME: PLEASE PRINT _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: (Self, Parent, Guardian) Circle one.

Witness: _____ Date: _____