WELCOME TO INNATE LIFE CENTER

Last Name: _____ First Name: _____ M.I.: ____
What name do you prefer to go by? _____
Address: _____ APT #: _____
City: _____ State: _____ Zip Code: _____
Email (for office use only): _____
Home Phone: (_____) _____ Work Phone: (_____) _____EXT_____
Cell Phone: (_____) _____ Fax Line: (_____) _____
Date of Birth: ____/____/____ Sex: □ M □ F SSN: _____ Height _____ Weight _____
Spouse's name: _____ _____ Phone: (_____) _____
Emergency contact other than Spouse:
Name: _____ Relation: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
How did you hear about us/whom may we thank for referring you? _____

Have you had an accident (major or minor) within the past 2 years? □ NO □ YES
If yes, what type of accident? □ AUTO □ WORK □ OTHER: _____
If yes, what date and time did this accident occur? ____/____/____ _____:_____ am pm
If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the front desk for the "accident questionnaire" at the time.
Are you seeking care due to an auto of work injury? □ NO □ YES Initial Here: _____

Do you have primary health insurance policy? □ NO □ YES
Do you have a secondary health insurance policy? □ NO □ YES
If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. ***Most insurance companies cover our services.***
Policy Holder's Name: _____ Date of Birth: ____/____/____ SSN: _____
Relation to Policy Holder: □ SELF □ SPOUSE □ CHILD □ OTHER: _____
Your Marital Status: □ S □ M □ D □ W □ Legally Separated
Your Student Status: □ Full-time □ Part-time □ Non-student
Your employment status: □ Full-time □ Part-time □ Retired
Your Employer: _____ Spouse's employer, if married: _____
I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary. Initial Here: _____

Your initial visit today will include an extended evaluation with Dr. Jonathan J. Levine, D.C. If necessary, x-rays will be taken. Because you are here due to an accident, the regular fees for today's visit will be paid in full by auto or worker's compensation insurance. **If your claim is denied, we will ask you to pay for today's visit.**

Signature: _____ Date: _____

Worker's Compensation Questionnaire
(Please Print Clearly)

Accident Information

Last Name: _____First Name: _____M.I.: ____
Date of auto accident:____/____/____ Time: ___:___ am pm
Name and address of the location your injury took place at: _____
_____
_____
Street Suite/Apt# City, State Zip

I am **RIGHT LEFT** Handed. (please circle)
Were you hospitalized for this injury? □NO □YES
Name of Hospital: _____
Date you were hospitalized: ____/____/____ Date of discharge: ____/____/____
Treatment received: _____
Did you see any other doctors for your injuries? □NO □YES
Name of doctor: _____
Type of doctor: D.C. M.D. D.O. Other: _____
Treatment received: _____
Please list your complaints and areas of pain in detail: _____
_____
_____
Where did you feel symptoms (in body) immediately after the injury? _____
_____
Please describe how your **BODY FELT** and your **PHYSICAL CONDITION**:
DURING the accident: _____
IMMEDIATELY AFTER the accident: _____
LATER that day: _____
THE NEXT day: _____
Do you have any existing impairment(s) affecting your present condition? □NO □YES
Are you able to do the *same* type of work you preformed at the time of injury? □NO YES
Are you able to do a *lighter* type of work you preformed at the time of injury? □NO YES
Before this injury, were you capable of working on an equal basis with others your age? □NO YES
Have you ever injured this area before? □NO YES,
If yes, When? ____/____/____
Did you fully recover from this injury? □NO YES
Since this injury are your symptoms: □ Getting Worse □ The Same □ Improving
Did you report this accident to your supervisor? □NO □YES (if no, please report ASAP)
In your work, do you need to favor any body part(s)? □NO YES
If yes, list: _____

Attorney & Witness Information

Were there any witnesses? □NO YES
Witness Name: _____ Phone: (_____)_____
Have you retained an attorney? □NO YES
If yes, attorney name/firm: _____
Address: _____ Phone: (_____) _____
Please notify your attorney that you have chosen Dr. Jonathan J. Levine, D.C. & do not wish to be referred elsewhere.

Please check all that apply

□ Headaches	□ Irritability	□ Numbness in toes	□ Buzzing in Ears
□ Neck pain	□ Chest pain	□ Shortness in breath	□ Faced Flushed
□ Neck stiff	□ Dizziness	□ Fatigue	□ Loss of balance
□ Upper-back pain	□ Head seems heavy	□ Depression	□ Fainting
□ Mid-back pain	□ Sensitivity to light	□ Loss of taste	□ Difficulty Sleeping
□ Low-back pain	□ Ringing in Ears	□ Loss of memory	□ Nervousness
□ Shoulder pain	□ Stomach Ache	□ Cold hands	□ Sleeping problems
□ Arm Pain	□ Loss of smell	□ Tension	□ Pins/Needles in *legs*
□ Leg pain	□ Visual Weakness	□ Diarrhea	□ Numbness in *fingers*
□ Cold feet	□ Constipation	□ Cold sweats	□ Pins/Needles in *arms*
□ Fever	□ Other: _____		

Family Medical history: **PLEASE CHECK ALL THE APPLY**

□ Cancer	□ Stroke	□ Seizures	□ Diabetes	□ Osteoporosis
□ Abnormal Blood Pressure		□ Cardiovascular Disease		□ Other: _____

Work Related Information

Do you notice any restrictions as a result of this accident? □ NO □ YES
If yes, describe: _____
Your occupation: _____ □ Part-time □ Full-time
Have you lost time from work as a result of this injury? □ NO □ YES
If yes, what dates were you unable to work? ____/____/___ through ___/____/___
Are you being compensated for time lost from work? □ NO □ YES

By signing below, I hereby certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

_____ _____ ____/____/____
Signature of Patient/Guardian Print Name Date

HIPPA Health Care Authorization Form (Privacy Practices)

All information you provide us with is confidential in nature and will only be referenced or shared with you, insurance companies, providers and billing or legal facilities who provide us with a signed request. By signing this form I give permission to **Dr. Jonathan J. Levine, D.C.'s** Office to use all information I provide, as this office deems appropriate.

In addition, by signing below I give this office permission to:

- ❖ Send me correspondence and provide me with health & other related information.
- ❖ Call and/or leave messages for me on an answering machine and/or voicemail.
- ❖ Provide health care professionals & others with my information when requested.
- ❖ Allow staff and other patients to view my name on the sign in register/sheet.
- ❖ Treat me in a semi-open room where others may see me if passing by in the hall.
- ❖ File a health care provider lien to bind insurance companies to forward payment.
- ❖ Display any testimonials I may write.
- ❖ Forward to/request my records from providers, attorneys & insurance companies.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

By signing this form I am giving **Dr Jonathan J. Levine, D.C.'s Office** permission to use and disclose my private protected information in accordance with the directives listed above.

Acknowledgement of Receipt of Notice of Privacy Practices

Please feel free to read the binder located in the front reception counter. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:

- ❖ I have the right to review the notice prior to signing this consent.
- ❖ I have the right to object to the use of my health information for directory purposes.
- ❖ I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

This authorization shall expire on the following date: *No Expiration Date*

The patient identified below authorizes Dr. Jonathan J. Levine, D.C.'s Office to use and disclose protected health information in accordance with all items described.

Print Patient Name: _____ Date of Birth: ____/____/____

_____	_____	____/____/____
Signature of Patient/Guardian	Print Guardian Name, *if applicable*	Date

Innate Life Center, L.L.C
Dr. Jonathan J. Levine, D.C.
3330 South Price Road, Suite D-110 Tempe, Arizona 85282
Phone: 480.345.2080 Fax: 480.345.2199

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care of this basis.

_____	_____	____/____/____
Signature of Patient	Print Name	Date

****

Consent to evaluate and adjust a ***minor***:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____	_____	____/____/____
Signature of Parent/Guardian	Print Name	Date

****

Pregnancy Release - For Female Patients ***only***:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: ____/____/____

_____	_____	____/____/____
Signature of Patient	Print Name	Date

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

The average office visit fee applied to all insurances is 199.00

You are only responsible for a daily co-payment and, if applicable, payment(s) toward any remaining annual deductible. Our office will discuss your financial responsibly with you.

FEES APPLIED TO ALL INSURANCE COMPANIES	
Initial new patient evaluation/consultation 2nd opinion (99273)	$190.00
Initial new patient detailed evaluation /consultation (99203)	$150.00
X-ray series of 5 (72040-72100)	$250.00
Report of x-ray/orthopedic findings between doctor and patient (99272)	$150.00
Muscle Testing (95831 or 97750)	$150.00
Computerized Range of Motion Test with report (95851)	$210.00
Extended daily re-examination/evaluation of patient (99213-25)	$70.00
Computerized neurological/temperature graph instrumentation (93740)	$40.00
3-4 region spinal adjustment/CMT (98941)	$55.00
Therapeutic exercise (97110)	$45.00
Therapeutic activates (97530)	$46.00
Neuromuscular re-education (97112)	$35.00
Myofacial release (97140)	$44.00
Cold or Hot therapy spray	$20.00

The above fees are based on Fee Facts pricing, a consensus/poll of doctor's fees nationwide.
Many of the above fees are billed to the insurance company on the same date of service.

I understand the average daily office visit fee applied to all insurance companies is $199.00. I understand each code and/or multiple codes above will be billed to my insurance company on the same date of service. I accept these fees and understand the doctor is to be paid in full for all services I receive. I understand, as a service to me, the doctor pays a billing service and a documentation service then awaits reimbursement from my insurance company. By signing below, I make known the co-insurance payment of my care would be a financial hardship to me.

I am only responsible for a daily co-payment and, if applicable, payments(s) toward my annual deductible, while my health insurance is being billed.

I understand if my care is associated with an auto, work, injury or accident claim, all bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand automobile insurance and worker's compensation insurance pay for the accident care in full. **Most auto and work injury care is provided at no out of pocket cost to me.**

I further agree, if any insurance company refuses payment, to authorize the doctor to file suit in small claims court, on my behalf, against the insurance company, as a method of collection. I agree to be present at the court date if needed. I also agree to filing a lien all insurance companies responsible for payment. **I have fully read and understand these terms and fees.**

_____ _____ ____/____/____

Signature of Patient/Guardian Print Name Date

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT
AUTHORIZION TO ISSUE CHECKS AND DRAFTS TO DOCTOR

To: _____
Insurance Company responsible for payment

1. I, _____ ID#_____,
   Patient's Name
   do hereby **AUTHORIZE AND DIRECT** any and all checks or drafts relative to treatment rendered by Dr. Jonathan J. Levine, D.C., which are issued by the above named insurance company, and which represent sums payable to me, the patient, or on my behalf be made payable to the order of:
   Dr. Jonathan J. Levine, D.C.
   3330 South Price Road, Suite D-110
   Tempe, Arizona 85282
   I authorize all relative health care payments be made out to doctor and forwarded to doctor's office.
2. I further **AUTHORIZE AND DIRECT** you to send all of said checks or drafts to:
   Dr. Jonathan J. Levine, D.C.
   3330 South Price Road, Suite D-110
   Tempe, Arizona 85282
3. I further **AUTHORIZE AND DIRECT** Dr. Jonathan J. Levine, D.C. to provide care to me and to release all of my health care information necessary for the processing and payment of any health insurance claim he submits in relation to my care.
4. I understand Jonathan J. Levine, D.C. is providing care and waiting for reimbursement from the insurance company as a service to me. In order for this service to continue I hereby grant, Jonathan J. Levine, D.C., Power of Attorney to negotiate any draft or check amount for the services rendered by Jonathan J. Levine, D.C.'s office. In the event the insurance company denies payment, Jonathan J. Levine, D.C. may retain the unpaid balance of his bill for all care provided to me in this office, through small claims court, at 100% of his billing. Any amount paid the put of pocket for relative dates of service will be forwarded to me, the patient, directly, after the doctor's bill has been satisfied in full.
5. Our office will make every effort to collect from he insurance company. Our success rate is excellent. However, if these efforts are exhausted, and the services of a collection agency become necessary, I understand I will be responsible for the agency fees at thirty percent of my total bill (the insurance company will be billed first).

In the event any insurance company obligated by contracted agreement to make payment to me or to Jonathan J. Levine, D.C. refuses to make such payment upon demand by Jonathan J. Levine, D.C., I hereby agree to sign a small claims action at that time, or personally reimburse the doctor and pay my balance in full at that time. If Jonathan J. Levine, D.C. is not reimbursed within a reasonable amount of time from the date of dismissal from this office, or if I do not reimburse him directly and pay my balance in full, I hereby assign and transfer Jonathan J. Levine, D.C., the cause of action that exists in my favor against any such insurance company, and authorize Jonathan J. Levine, D.C. to prosecute said action, either in my name or the insurance company's name, and further authorize Jonathan J. Levine, D.C. to file a lien and collect on his said portion of the claim for amount of services he provides.

By signing below the co-payment of care would be a financial hardship to me:
Witness: _____
A copy of this form shall be sent to all payers & copies shall be as valid as the original

_____ _____ ____/____/____
Signature of Patient/Guardian **Print Name** **Date**

MEDICAL REPORTS AND DOCTOR'S LIEN

If I retain an attorney, I direct my attorney to note ***my doctor of choice*** for accident care: I authorize and direct said attorney to pay my accident bills to pay my accident bills in full directly to my doctor:

Dr. Jonathan J. Levine
3330 South Price Rd, D-110
Tempe, Arizona 85282
Office: 480.345.2080 Fax: 480.345.2199 Mobile: 480.206.5039
Tax ID: 86-0828044

I hereby authorize and direct my doctor, Dr. Jonathan J. Levine, D.C. to:

- ✓ Correspond with the attorney representing me in regards to my accident claim.
- ✓ Furnish my attorney with all medical records produced in Dr. Jonathan J. Levine's office.
- ✓ Provide my attorney and all insurance companies with extended examination reports, diagnosis, prognosis, daily progress notes, treatment notes, dismissal report, bills, and all records produced in this office prior to or during my care.
- ✓ To file a lien holding all liable parties and carriers responsible for payment.

I hereby authorize and direct you, my attorney, to:

- ✓ Correspond with Dr. Jonathan J. Levine, D.C., my treating physician, concerning my accident.
- ✓ Inform Dr. Jonathan J. Levine, D.C. regarding the status of my case.
- ✓ Pay Dr. Jonathan J. Levine, D.C. directly a;; sums of money due him for services rendered to me.
- ✓ Forward all medical payments to Dr. Jonathan J. Levine, D.C. immediately as received.
- ✓ To withhold all sums of money from any settlement, judgment, or verdict as may be necessary to protect Dr. Jonathan J. Levine, D.C.
- ✓ To pay my accident care in full to Dr. Jonathan J. Levine, D.C. and issue all checks/drafts to him and to forward all said checks/drafts to his office address above/
- ✓ To honor the recorded lien and my request and make payment(s) to Dr. Jonathan J. Levine, D.C.

FOR ATTORNEY'S USE ONLY:

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Dr. Jonathan J. Levine, D.C.

_____ _____ ____/____/____

Attorney's Signature **Attorney's printed name** **Date**

Please sign, date and return original to doctor's office. Keep a copy for your file.

A photocopy of this document shall be considered as valid as the original.

_____ _____ ____/____/____

Signature of Patient/Guardian **Print Name** **Date**