Tuttle DeLucchi
Chiropractic & Massage

Patient Name____ Date: ______________

SS #/SIN________________________ DOB_____/_____/________ Age________ ☐ Male ☐ Female

Home/Cell #____________________ Work #_________________ Email: ___________________@_______

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _________________________________City ________ State_____ Zip___________

Employer Name: ____

Whom may we thank for referring you? ____

Person to contact in case of an emergency_________________________ Phone___________________________

Responsible Party

Name of The Person responsible for this account ______________________Relationship to Patient ______________________

Address ____Home/Cell #___________________________

E-Mail ____Work # ______________________________

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Insurance Company________________________ Name of the insured_________________________________

Birthdate______________ Health Card ID Number____________________________ Group #________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Tuttle DeLucchi Chiropractic and Massage as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of ________________, 20 ____.

X___________________________________ (SEAL)
(patient signature)

X_____________________________________(SEAL)
(signature of Guardian if applicable)

X___________________________________
(please print patient name)

Tuttle DeLucchi
Chiropractic & Massage

Health History

Patient Name: ____________________________DOB: ___________________Date:_____________

Chief Complaint: ____

History of Present illness:

Location: ____
(Where is the pain/problem?)

Quality: ____
(Example: normal vs abnormal color, activity, etc..)

Severity: ____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ____
(How long have you had this pain/ problem? When did it start?)

Timing: ____
(Does the pain/problem occur at a specific time?)

Context: ____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms :______________________
____
(What other associated problems have you been having?)

Modifying Factors:_________________________________
____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History(Circle)

☐Numbness	☐Measles	☐Anemia	☐Back Trouble
☐Mumps	☐Bladder Infection	☐High Blood Pressure	☐Ulcer
☐Chicken Pox.	☐Epilepsy	☐Low Blood Pressure	☐Kidney Disease
☐Whooping Cough	☐Migraine Headaches	☐Hemorrhoids	☐Thyroid Disease
☐Scarlet Fever	☐Tuberculosis	☐Stroke	☐Bleeding Tendency
☐Diphtheria	☐Diabetes	☐ Asthma	☐Hepatitis
☐Small pox	☐Cancer	☐Hives of Eczema	☐Joint Swelling
☐Pneumonia	☐Polio	☐AIDS & HIV	
☐Rheumatic Fever	☐Glaucoma	☐Infectious Mono	☐Other medical conditions my practitioner should know:
☐Arthritis	☐Hernia	☐Bronchitis	(Please List):
☐Venereal Disease	☐Blood or Plasma	☐Mitral Valve Prolepses	

Previous Hospitalizations/Surgeries/Serious Illnesses When?

____ _____________________
____ _____________________

Medication: (include nonprescription)

____
____

Patient Social History:

Marital Status	Single: ______	Married: ______	Separated: _______	Divorced: _______	Widowed: _______
Use of Alcohol	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Tobacco	Never: ______	Rarely: _______	Moderate: _______	Daily: ________	
Use of Drugs	Never: ______	Type/Frequency: ________________________________			

Excessive Exposure
At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: _______ Noise: _______

CLINICIAN SIGNATURE: ______________________________________ **DATE REVIEWED:**_____________________
PATIENT NAME: ____________________________________ **DATE:**________________________________

Name:____ DOB ________________ Date:_________________

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_________	_______________________	_______________________
Mother	_________	_______________________	_______________________
Siblings	_________	_______________________	_______________________
Spouse:	_________	_______________________	_______________________
Children:	_________	_______________________	_______________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache/Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain between shoulder blades	1 2 3 4 5

- □Yes □No Broken bones in last 2 years
- □Yes □No Injuries in past 2 years
- □Yes □No Sensitive to touch in certain area
- □Yes □No Bruise easily
- □Yes □No Contagious diseases
- □Yes □No Pregnancy? (# Weeks______)
- □Yes □No Sensitive to touch in certain area
- □Yes □No Epilepsy/seizures
- □Yes □No Cardiac/circulatory problems
- □Yes □No Allergies:

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5
Stress	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Loss of Sleep	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ________________

Signature of the Patient, Parent or Guardian Date

Doctor's Review

____ ________________

Signature of Doctor **Date**

Name:____ DOB _________________ Date:__________________

Tuttle DeLucchi

Chiropractic & Massage

Informed Consent

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient/Guardian Signature_______________________ Date ___________Witness Signature ________________________ Date_________

HIPPA Disclosure

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Photo release

We are PROUD of our patients and the progress they make while under our care! There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results! Please check the box that applies to you:

☐ Sure! You can use my picture on the Tuttle DeLucchi Website and Social Media (i.e. Facebook, Instagram, etc.) pages, as long as I look good in it!
☐ No thanks! I'll pass for now

X-Ray Release

It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. Please select from the following:

☐ Sure! Do whatever you feel is necessary to come up with the best care plan for me (and, NO, I am certainly NOT pregnant).
☐ No thanks! I'll pass for now, as I am pregnant or have another medical condition which contradicts me being exposed to x-ray.

I attest that the information on this form including HIPPA Disclosure, Photo Release, Xray Release, and those preceding, is true and accurate to the best of my knowledge.

Patient/Guardian Signature_______________________ Date ___________Witness Signature ________________________ Date_________

OFFICE/PATIENT AGREEMENTS

It has been our experience, caring for thousands of patients over the last 30+ years, that those who agree to and understand the following agreements can benefit the most from their care in our office, helping save you time and money. This keeps the focus on the big issue- retaining and maintaining your health.

Your Consistency of Visits: Our recommendations for your care are customized to your health goals and your body's needs. You need to keep the recommended number of visits consistent in order to get the best results:

- Meet all you appointments(arrange your activities so you can do this)
- Call us with any emergencies so we can reschedule you
- Come in for care even when you have "the bug"
- Choose an alternate day of the week to make up missed visits

Re-Examinations: In order to monitor your progress, you will receive a re-examination about every three-six weeks where you will be with one of our health professionals and review your progress since your last examination. New injuries may also require an exam.

Payment of Bills: the following payment schedule is an attempt to allow the patient to receive the care he/she needsWe will expect you to honor the financial agreement you make with our office; If you find that you cannot fulfill the agreement you have made with us, you need to go to the front desk, and tell one of our staff so that we can discuss with you new arrangements to be made. Insurance companies will be billed for your services rendered if you have such insurance coverage. If you receive any checks from your insurance company, it is your responsibility to bring them into our office within 3 days of receiving them along with the "Explanation of Benefits" attached to the insurance check. If you fail to bring in the insurance checks and/or the "Explanation of Benefits", we reserve the right to bill you directly for those services.

Insurance: It is important that you understand that health and accident insurance policies are an agreement between the insurance carrier and you, the patient, their insured. At Tuttle DeLucchi Chiropractic will prepare all necessary documentation to assist you in making collection from the insurance company. Any payment paid directly to Tuttle DeLucchi Chiropractic will be credited to your account upon receipt.
However you must clearly understand and agree that all services rendered to you are charged directly to you and you are personally responsible for payment. In order to facilitate rapid processing of your insurance claim, we suggest you call your insurance agent and find out what coverage you have including your deductible amount and how much of your claim your insurance company will pay.

1. Obtain insurance forms from your agent/company and fill out all information regarding any injury
2. When bringing insurance information in, please ask a Tuttle DeLucchi Chiropractic team to verify the correct information to avoid errors
3. If you are in an on-the-job injury or motor vehicle accident, we suggest you discuss your coverage with our insurance office. We have suggestions that will help you in this regard
4. You will be asked to authorized Tuttle DeLucchi Chiropractic to furnish any information regarding your case directly to your insurance company and assign all benefits as a result of the claim. This will expedite the claim
5. Please be informed your own insurance coverage, however if you have any questions feel free to ask. Our team is experienced in insurance claims handling and will be glad to assist in any way that we can.

Upsets: If you ever have any questions or concerns of any fashion concerning your care in our office, please talk to a staff member immediately so we can answer your questions and help you.

Massage Therapy: Missed massage therapy appointments require 24 hour notice to cancel. Failure to cancel before 24 hours will result in a cancellation fee of $40.00. Two or more last minute/No show fee is set at $70.00 per occurrence. Any fees incurred from previously listed violations must be paid before more sessions can be scheduled.
*If you are running late 15 minutes or more your session my be shortened or cancelled.

I fully understand and accept these policies.

____ ______/______/______
Patient Signature Date

Name:____ DOB __________________ Date:___________________