Highest Health
chiropractic

4215 W 57th St. Sioux Falls, SD 57108
Phone #: 605.610.8801
Fax #: 605.653.2433

To our valued practice member,

We are truly sorry for the circumstances that have brought you to our office. Our focus is providing you with the best possible care so that you can recover as quickly as possible.

Prior to scheduling, we NEED to have the information listed below:

If we don't have this information unfortunately, we can't proceed forward!

1. Drivers License
2. Your Auto Insurance Card (If an Auto case)
3. New Practice Member Paperwork
4. PI-WC-AUTO Intake Form (must fill in highlighted areas)
5. PI-WC-AUTO Questionnaire
6. HHC Lien Signed

Once your case is confirmed to be open and billable, we will reach out to you to schedule your first appointment in our office as quickly as possible!

Additional Information that is helpful to provide us with:

- Your Auto Declaration Page listing coverage (This is from your Auto Insurance Agent)
  - Can be faxed to us from agent
- Accident/Incident Report (Police Report)

Thank you in advance for providing all the above information so we can properly serve you.

Yours in health,
Team HHC

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NEW PRACTICE MEMBER APPLICATION

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Social Security #: _____ Driver's License #: _____

Cell Phone #:_____ Home Phone #:_____

Email:_____

Occupation_____ Employer's Name_____

Name of Emergency Contact & Relationship: _____ Phone #:_____

What is the primary way you heard about us/who referred you?_____

What are all the ways you have heard about us or researched us? Please check all that apply.

- ☐ Highest Health Practice Member
- ☐ Non-Practice Member
- ☐ HHC Team Member (staff)
- ☐ Instagram
- ☐ Facebook
- ☐ Google
- ☐ HHC Website
- ☐ PX Website
- ☐ Other

Circle if applicable: Veteran / Reservist/National Guard / Active Duty / Clergy / First Responder

Martial Status: Single / Married / Divorced / Widowed

Spouse's Name_____ Spouse's Employer: _____

Number of Children_____ Names, Ages, & Gender_____

List The Health Concerns That Brought You Into This Office

Health Concern(s): List according to severity.	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

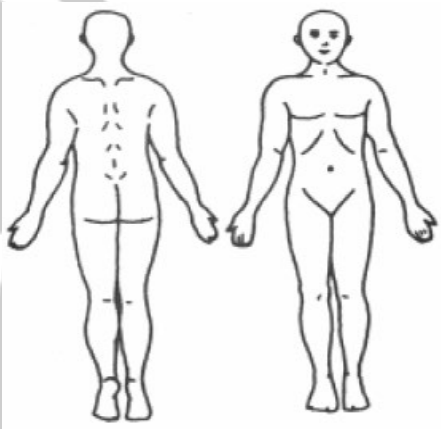
Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

___Pregnant: Due Date?:_____ ___Stroke ___Cancer ___Heart Attack ___Spinal Surgery

___Spinal Bone Fracture ___Scoliosis ___Diabetes ___Arthritis ___Seizures Other:_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:



R = Radiating **B** = Burning **D** = Dull **A** = Aching

N = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms?

_____

What makes your symptoms feel worse?

_____

When is the problem(s) at its worst? → AM PM Mid-Day Late PM

_____

Please identify any & ALL types of jobs you have had in the past that have imposed any physical stress on your body:

_____

List all surgical operations & years:

_____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

List all over the counter & prescription medications you are on, & the reason for each:

_____

Have you ever been in an auto accident?

List all:_____

Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

_____

Other trauma:_____

Do you have any health conditions that elicit a medical emergency? Including EpiPen, pace maker, etc.

_____

SOCIAL HISTORY

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Recreational Drug Use: How often? □ Daily □ Weekends □ Occasionally □ Never
5. Have you consumed any caffeine or products with caffeine in the past 48 hours? □ Yes □ No

_____ _____-_____-_____

Practice Member or Authorized Person's Initials Date Completed

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

Back pain Headaches

0 1 2 3 (4) 5 6 (7) 8 9 10

1. How would you rate your pain RIGHT NOW?

_____

0 1 2 3 4 5 6 7 8 9 10

2. **What is your typical or AVERAGE pain?**

_____

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level at its BEST? (How close to 0 does your pain get at its best?)**

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. **What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Example: Climbing stairs	I can climb 2 flights before it hurts	I used to climb 10+ fights without pain
LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HEALTH HISTORY

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Acknowledge & Initial Here: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke. Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to the doctors at Highest Health Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment. This pertains to any and ALL services rendered.

Acknowledge & Initial Here: _____

NO CALL NO SHOW POLICY

In our office we reserve our time to serve you and your family. We understand that life happens, and appointments may need to be changed or canceled for emergent reasons. In this event we request that you give our office a call ASAP to change your scheduled appointment OR use your SKED appt. on your phone. We base our schedule and staffing needs on the anticipation of everybody making their appointments, making each scheduled appointment very important. Most importantly, it affects our committed practice members and others who rely on their scheduled time and who could have taken someone else's missed appointment spot. TWO "no call no shows" for regular adjustments are granted to a practice member in the event of an emergency, but there is no tolerance for chronic "no call no shows". Following the 3rd "no call no show" our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day. For special appointment codes that require an evaluation room and a team member (Example: reevaluations, x-rays, Annual Health Reviews, etc.) our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day for all missed special appointments. Ultimately, being consistent with your care will yield the best results for your health.

- I understand the above cancellation policy as well as the penalty fees that may be applied to my credit/debit card.

Acknowledge & Initial Here: _____

HIGHEST HEALTH CHIROPRACTIC PHOTO RELEASE

I grant Highest Health Chiropractic and its employees the right to take photographs of me with connections to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Highest Health Chiropractic may use such photographs of me for any lawful purpose, including such purpose as publicity, illustration, advertising, and web content.

Acknowledge & Initial Here: _____

By signing below, I am acknowledging and consenting myself or my minor/child to the above initialed sections (Notice of Privacy Practices Acknowledgement, Informed Consent for Chiropractic Care, & Photo Release)

_____ _____-_____-_____

Practice Member or Authorized Person's Signature Date Completed

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Upon request, your x-rays can also be available for an additional $5 cost. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Highest Health Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY ⬇: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Highest Health Chiropractic.

□ The first day of my last menstrual cycle was on _____-_____-_____ (Date)

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: _____

I authorize the doctors and any and all Highest Health Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Highest Health Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

⬇ Doctor Use Only ⬇

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature _____

Office Name: _____ / Doctor: _____

Practice Member Name: _____

Date of Accident: _____ Time of Accident: _____ City: _____ State: _____

Practice Members Medical Pay Information

Do you have Medical Pay on your Policy? YES NO
If Yes, coverage amount: $1,000 $1,500 $2,000 $2,500 $5,000 $10,000 $_____

Personal Injury Claim #: _____

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension _____

Insurance Company Name, Address & Fax Number:

_____

_____

_____

Fax Number: _____

Attorney Information

Have you retained an attorney? YES NO

Attorney Name: _____ Firm: _____

Phone Number: _____ Fax: _____

Lien On File? Did attorney confirm they will pay provider directly?

Other Driver (At Fault Driver) Insurance Information

Name: _____ Claim #: _____

At Fault Driver's Insurance Company Name & Address

_____

_____

_____

Personal Injury Adjuster's Name: _____

Adjusters Phone Number: _____ Extension _____

At Fault States: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin & Wyoming

HIGHEST HEALTH CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

_____ _____

Patient's Name Date of Birth

Please answer all questions completely.

Please explain in detail how your accident happened:

_____

_____

_____

Date & Time of Injury

_____

Where did you feel pain immediately after the accident?

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Where were you taken after the accident? _____

Name of Hospital: _____

What tests (xray,MRI, etc…) were performed? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

---

Complete the section below only if this is an auto case

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Signatures

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

LIEN

Provider Name: Dr. Nate DeJong
Clinic: Highest Health Chiropractic
Address: 4215 W. 57th St, Sioux Falls, SD 57108

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Signature Date