Patient Information E-mail_____
(Please Print) Referred by: _____
First Name_____ Last Name_____ Middle Initial_____
Address_____ City_____ State_____ Zip_____
Phone: Home # (___) _____ Work # (___) _____ Cell # (___) _____
Employer _____ Address_____
Birth date_____ Social Security Number_____
Male Female Single Married Divorced Separated Driver's License # _____

Person Responsible for Account (If self, write "self")
Name_____ Relationship_____
Address_____ Home Phone (___)_____
City_____ State_____ Zip_____
Employer_____ Social Sec. #_____
Spouse Name_____ Employer_____

In Case of Emergency Contact
Name_____ Relationship_____
Address_____ Phone (___) _____

Insurance Information
Primary Insurance_____ Phone # (___) _____
Address_____ City _____ State_____ Zip _____
Name of Employee/Insured_____ Birth date_____
Insured SS#/ID#_____ Group/Claim #_____

Assignment of Insurance Benefits-Release of Private Information
I hereby assign my right to payment for services rendered from my insurance company to The Rosquist Group PC. I authorize them to act on my behalf to process claims with my insurance company and to receive payment for the treatments they perform. I further authorize Dr. Rosquist and his staff to release confidential medical information to my insurance company as needed to process the insurance claims.

Financial Terms & Promise to Pay
I agree to pay for all services performed on my behalf by Dr. Rosquist and his staff. I understand that my insurance may not pay for all charges and I agree to promptly pay for all services rendered regardless what amount my insurance actually covers. I understand and agree that payment is due at the time service is rendered.

Terms
In the event that I do not pay for services rendered on my behalf at the time of service, I agree to pay a finance charge on the unpaid balance at the rate of eighteen percent annual percentage rate (18% APR). Should the services of a collection agency or attorney be required to enforce my payment obligation, I agree to pay any and all additional collection surcharges plus all attorney's fees and court costs incurred, with or without a suit, to do so.

Signed _____ Date _____

Dr. Gary Rosquist
Chiropractic and Acupuncture Clinic
3409 W 12600 South Suite 200
Riverton UT, 84065

Consent for Use of Disclosure of Health Information

Our Privacy Pledge:

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and will always respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnoses, assessment or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you for your referrals, acknowledge your referral on an in-office referral board, send you a welcome to our office, invite you to participate in patient appreciation events, send you an office newsletter or send promotional information.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will verify to you in writing when you come for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

We will not provide your health information to any individual, company or organization without your signed authorization except as mentioned above.

Your Right to Revoke your Authorization:

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

PATIENT ACKNOWLEDGEMENT REGARDING NOTICE OF PRIVACY PRACTICES THE ROSQUIST GROUP, P.C.

I have had the opportunity to review the Notice of Privacy Practices at The Rosquist Group, and, if requested, have been supplied with a copy of those practices.

Patient Name: _____ Date: _____
(Print name)

Patient Signature: _____

****

The HIPPA Privacy rule gives individuals the right to request confidential communications or that a communication of private health information be made by alternative means, such as sending correspondence to the individual's office, instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

[ ] Home Telephone
- [ ] OK to leave message with detailed information
- [ ] Leave message with call-back number only

[ ] Work Telephone
- [ ] OK to leave message with detailed information
- [ ] Leave message with call-back number only

[ ] Written Communication
- [ ] OK to mail to my home address on file
- [ ] OK to mail to my work office address
- [ ] OK to fax to this number _____

Patient Signature: _____ DOB: _____ Date Signed: _____

Problem Survey

Many of our patients are taking medications to treat various health conditions. We understand people want an alternative to drugs and surgery for treatment and preventative health care. Most People would like to discontinue taking drugs and use a more natural or holistic means of addressing their health concerns. Unfortunately, they do not know where to go and how to get the help they need for this type of approach. All medications have side effects. Many are very serious. The journal of American Association, 1998; 279: 1200-5 states that 106,000 Americans die each year from the side effects of medications prescribed by their medical doctors.

Dr. Rosquist is a member of the Academy of Integrative Health Services (IHS). IHS has developed protocols using whole food supplements, homeopathy, dietary changes, blood chemistry and body fluid analysis, exercise and acupuncture, along with standard chiropractic care. We monitor a patients improvement objectively through blood chemistry analysis as well as symptomatically. The protocols we use for the conditions below have little, if any, adverse side effects. Please check the boxes for the problems you would like to discuss with the doctor.

- ☐ Acne
- ☐ Allergies (food,respiratory)
- ☐ Anemia (iron, pernicious)
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Atherosclerosis (clogged arteries)
- ☐ Attention Deficit Disorder (ADD, ADHD)
- ☐ Autoimmune Disease (gluten sensitivity)
- ☐ Candidiasis (Yeast Infection)
- ☐ Celiac Disease (Gluten Sensitivity)
- ☐ Cholesterol problems
- ☐ Colic
- ☐ Colitis
- ☐ Dermatitis, Eczema
- ☐ Failure to thrive
- ☐ Fatigue
- ☐ Fever Blisters (cold sores, Herpes)
- ☐ Gastro Esophageal Reflux Disease
- ☐ Gout
- ☐ Heart Function
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypoglycemia
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Stones
- ☐ Liver problems
- ☐ Mastitis
- ☐ Menopause
- ☐ Muscle Cramps, Spasms
- ☐ Osteoarthritis
- ☐ Otalgia (Earache)
- ☐ Pharngitis (Sore throat)
- ☐ Phlebitis, Thrombophlebitis
- ☐ Prostate problems
- ☐ Premenstrual Tension (PMS)
- ☐ Seizure Disorders
- ☐ Shingles
- ☐ Sinusitis (Bacterial, Allergic, Viral)
- ☐ Thyroidism (Hypo, Hyper)
- ☐ Urinary Tract Infection (UTI)
- ☐ Urticaria (Hives)

Comments or questions about other conditions:

Visual Analogue Pain Scale

Patient Name:_____ Today's Date:_____

How much pain have you had because of your condition in the past week?
Please mark on the line to indicate how severe your pain has been.

ROSQUIST CHIROPRACTIC & ACUPUNCTURE CLINIC
Board Certified Chiropractic Orthopedist, Licensed Acupuncturist

GARY ROSQUIST, DC, LAc

You have asked our office to bill your health insurance in order to help reduce your outstanding balance as well as help reduce future interest charges. We are happy to bill your health insurance provided the following is understood and agreed upon. State insurance regulations will allow us to bill your health carrier, which may help reduce any outstanding balance. However, any policy provisions or opinions from your health insurance that result in non-payment or reduced payment of claims submitted will not affect your personal injury account that is protected by lien.

Many bills are reduced or discounted by health insurance carriers with the statement, "Due to the PPO contract, this portion is the responsibility of the provider," or other similar statements. Our contact with you that includes an Assignment of Benefits and Lien (copies of which are attached hereto) supercedes any other contract you may have with insurance carrier. We will credit your account by all amounts paid, but will not credit any amount that is discounted or reduced by your health carrier.

Any unpaid balance should be paid by the settlement you receive, however should the settlement be inadequate or if there is no settlement you remain personally responsible for the balance. By singing below, you agree to these terms relating to you personal injury account with our office.

_____
Patient's Name (print)

_____
Patient's Signature

_____
Date

_____
Witness Signature

3409 West 12600 South • Riverton, Utah 84064 • (801) 676-8770 • Fax (801) 676-8772 • Email: rosquists@hotmail.com

the ROSQUIST group PC

DR. GARY ROSQUIST
Board Certified
Chiropractic Orthopedist
Licensed Acupuncturist

Patient Name_____

This primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. Dr. Rosquist will use this procedure in your treatment program.

The nature of chiropractic manipulation:

We will use our hands to manipulate or loosen and reposition the joints of your spine and or extremities. Often with this procedure, you will hear a popping noise associated with the loosening and repositioning of spinal or extremity joints. This is a normal occurrence.

The material risks inherent to chiropractic manipulation:

As with any health care procedure, there are certain complications or risks that may arise from chiropractic manipulation. These complications may include aggravation of degenerative joints, or injured spinal disks, rib fractures, ligament sprains, muscle strains, nerve injury, spinal cord compression and ruptured breast implants. Ruptured breast implants are rare but have been reported with manipulation of the thoracic spine (mid back). Manipulation of the neck has been associated with injury to the arteries in the neck leading to or contributing to stroke. Local soreness and or stiffness are typical in the early phases of treatment. There is an increased risk of bone fracture to those individuals taking corticosterioids over an extended period of time. Please inform the doctor if you are taking this type of medication. Fractures are rare occurrences and generally a result from underlying bone weakness, which we check for when obtaining a history, and during examination and if necessary via x-rays or other imaging modalities.

Probability of those risks occurring:

The exact incidence of stroke is uncertain. Studies indicate stroke complications occurring as a result of cervical spinal manipulation to be anywhere from 1 in 400,000 to 1 in 3.8 million depending on the study. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition include:

-over the counter medications and rest
-medical care, which may include anti-inflammatory drugs, plus muscle relaxants and pain medications
-surgery
-physical therapy

Material risks inherent to your other treatment options:

The common analgesics and anti-inflammatory drugs have been shown to cause damage to the stomach and intestines and possibly to the kidneys. Approximately 1 in 150 patients taking anti-inflammatory drugs for extended time periods require hospitalization for stomach ulceration.

There are about 16,500 deaths in the US each year from these complications. The risks are similar for both prescription as well as over-the-counter anti-inflammatory medications.

Spine surgery may be a consideration for some cases. It, however, is reserved for those cases where extensive conservative therapy has been exhasuted. Spine surgery is associated with a minor complication rate of between 9 per 100 and 15 per 100 cases depending on the area of the spine involved. More serious complications of the nervous system may occur in 1 per 400 cases, and death has been reported in approximately 1 per 1500 cases.

While spinal manipulation is associated with complications in a smaller number of cases, it has a complication rate several thousand times less than other typical treatment options.

Consent to treat and release

I understand that the treatment I received from Dr. Rosquist and his staff may require them to come into physical contact with my body in order to properly perform chiropractic manipulation, acupuncture, ultrasound or other treatment modalities. I also understand that some treatment modalities may cause me some physical discomfort during and or following treatment or may invade my sense of privacy. I hereby voluntarily consent to Dr. Rosquist and his staff providing me such treatment as judged necessary by them and release them from any and all liability for doing so except for damages caused to be by their gross neglect.

Do not initial and sign until you have read and understand the above

I have read_____ or have had read to me_____ the above explanation of chiropractic manipulation or adjustment and related treatment complications. I have addressed any concerns I may have regarding treatment with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

Patient

Dated_____

_____
Printed Name

_____
Signature

Witness:

_____
Name

_____
Signature of Guradian (if a minor)

_____
Signature