



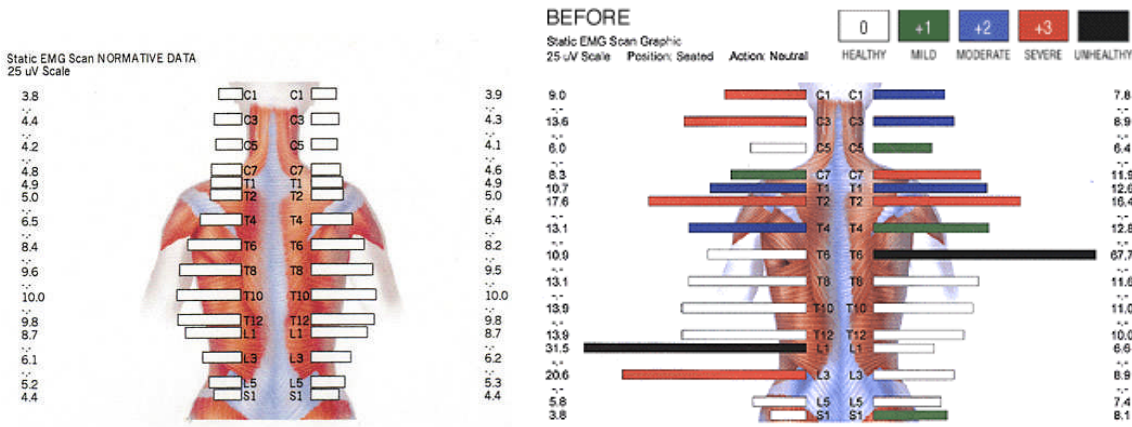
My mission is provide information, programs and support to help you live a long, healthy and active life."

Welcome to Hatlen Family Chiropractic, Cold Laser and Nutrition. My name is Dr. Gary Hatlen. I am a Palmer graduate and I have been practicing in the valley for over 22 years. I practice Neurologically-based Chiropractic Care. All pain involves the nervous system therefore a detailed neurological examination will be performed to determine the underlying cause of your health problems. This will include a computerized electro-diagnostic test (see pictures below) that detects the location and severity of spinal nerve problems. We achieve fast, effective pain relief by detecting and correcting the underlying cause of your health problem. I utilize the latest cold laser technology to stimulate the repair of tissue damage and accelerate pain relief.

Since your nervous system controls the health and function of your body you will also have an opportunity to improve your health and well-being. You experience your entire life through your nervous system so my mission is to help as many families as possible achieve optimal health through an optimum functioning nervous system.

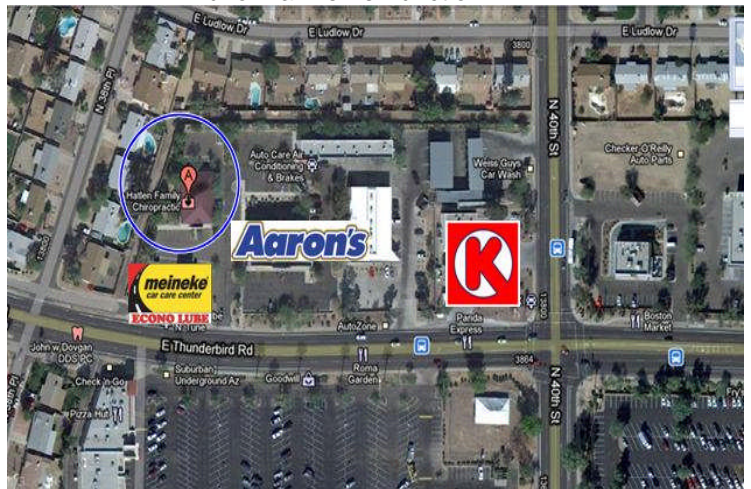
You will receive a complete report of my examination findings, diagnostic results and care recommendations.

Thank you for the opportunity to serve your healthcare needs. Dr. Gary Hatlen.



Normal Nerve Function

Abnormal Nerve Function



We are located at 3842 E. Thunderbird Rd. Suite 200
(West of 40th street on the north side of Thunderbird between Aarons and Meineke/Econolube)

Dr. Gary C. Hatlen, Hatlen Family Chiropractic, 3842 E. Thunderbird Rd., Ste. 200, Phoenix, AZ. 85032 (602) 443-4423



Date: / /

Last Name		First Name		M.I.
Street Address				
City		State		Zip Code
Best Phone Number to Reach You			E-Mail (For communicating important health and office information.)	
Your Employer			Your Occupation	
Date of Birth	Age	Social Security # (For insurance)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Number and Ages of Children			Height	Weight

Will you be using health insurance to supplement payment to our office? Yes No

If yes, please provide us with your insurance card and we'll make a copy. We will also verify your coverage.

Are you covered under someone else's insurance? No Yes Spouse Parent _____

Enter their information below:

Last Name		First Name		M.I.
Social Security # (For insurance)		Date of Birth (For insurance)		

Are you filing a worker's compensation claim? No Yes Date reported to employer: ____/____/____

We provide the following healthcare services. Check **ALL** the types of care that you are interested in receiving.

Wellness Care: I currently have no symptoms. My goal is to maintain the health of my spine and nervous system while preventing spinal degenerative disease.

Corrective Care: My goal is to achieve natural symptom relief and to maximally improve my posture, spinal alignment, mobility, strength, nerve function and health.

Rehabilitation Care: My goal is to achieve natural symptom relief and maximum healing of my injuries/tissue damage.

Relief Care: My goal is to achieve natural symptom relief without the dangerous side-effects of medications.

Cold Laser Therapy: My goal is to maximize the healing process and accelerate pain relief.

Nutritional Care: My goal is to use natural, drug-free, safe and healthier nutritional solutions for my health problems.

How did you find out about Dr. Hatlen? Referral Zip Code Yext Google/Internet My website

Who may I thank for referring you to my office? _____

Have you ever been to a Chiropractor before? No Yes Last visit? ____ weeks ____ months ____ years ago.

What type of care? Corrective/Rehabilitative Symptom relief care Regular maintenance/wellness care

What type of adjustments do you prefer? manual adjustments by hand instrument adjustments both

Who is your medical doctor? _____

When was your last visit to the medical doctor? ____/____/____ For: _____

Name: _____ Date: ____/____/____

PHYSICAL TRAUMA List any significant physical traumas from birth to the present (accidents, injuries etc.):

None _____

EMOTIONAL TRAUMA List any significant emotional traumas from birth to the present (deaths, divorce etc.):

None _____

HOSPITAL List any illnesses or conditions that required hospitalization or surgery:

None _____

DISEASE ♦ ILLNESS List any diagnosed diseases or conditions (such as diabetes, allergies, asthma etc):

None _____

FAMILY HEALTH HISTORY List any significant health problems involving parents or siblings (cancer, etc.)?

None _____

MEDICATION Are you currently taking any prescription or over the counter drugs? No Yes

List the medication and condition you are taking it for: _____

Any Side Effects? No Yes _____

DIAGNOSTIC TESTS Have you had any of the following diagnostic tests in the last 6 months? No Yes

x-rays MRI CT Scan Explain: _____

STRESS How would you rate your stress level? none mild moderate severe very severe

Do you feel stress is affecting your health? No Yes What do you feel is your #1 stress? _____

HABITS Do you smoke? No Yes How many years? _____ How many per day? _____

Do you drink more than two servings of alcohol per day on a regular basis? No Yes _____

PREGNANCY Are you pregnant? No Yes Unsure Due date: _____

EXERCISE Do you exercise? No Yes How many days per week? 1 2 3 4 5 6 7

Type of exercise? Cardio/Aerobics Weights Stretching Yoga Other: _____

NUTRITION How would you describe your diet? poor fair good excellent

How many servings of fruits and vegetables do you consume on a daily basis? _____

What daily nutritional supplements are you taking? Multi-vitamin Vitamin D3 Omega 3 (fish oil) Probiotics

Other: _____

HEALTH On a scale from 1 to 10, how would you rate your current state of health?

1	2	3	4	5	6	7	8	9	10
FAILING		POOR		FAIR		GOOD		EXCELLENT	

FITNESS On a scale from 1 to 10, how would you grade your level of fitness (strength, endurance etc.)?

1	2	3	4	5	6	7	8	9	10
VERY POOR		POOR		FAIR		GOOD		EXCELLENT	

COMMITMENT On a scale from 1 to 10, how committed are you to regaining your health and fitness?

1	2	3	4	5	6	7	8	9	10
NOT A PRIORITY		SLIGHTLY		MODERATELY		VERY		EXTREMELY	

In the last 5 years has your health been: getting worse getting better staying the same

HATLEN FAMILY CHIROPRACTIC (HFC) FINANCIAL POLICY AND CONSENT TO TREAT

Our goal is to work with each individual to help them receive the care they need.

☐ GROUP OR PRIVATE HEALTH INSURANCE

1. Health insurance is designed to supplement your out of pocket expenses for care. HFC will verify your insurance benefits and we will inform you of any deductibles and/or co-insurance payments.
2. HFC will file your insurance claims as a courtesy. HFC will not charge you for this service.
3. HFC does not employ a billing service for the collection of deductibles and/or co-payments; therefore your deductible payment or co-payment is due at the time of service.
4. Your insurance coverage is based upon medical necessity that is determined by the presence of physical examination findings that are responsible for your health complaints.
5. Insurance does not usually cover once a month wellness or maintenance care.
6. I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account or government managed health plan.
7. I authorize all insurance reimbursement for services rendered to be paid to Dr. Gary C. Hatlen.

☐ CASH PATIENTS

1. We do not employ a billing service; therefore payment is due at the time of service unless payment arrangements have been made.
2. We accept cash, check, debit, MasterCard, Visa and Care Credit.
3. Interest free payment plans are available to make the investment in your health affordable.

☐ CONSENT TO TREAT

I hereby consent to and authorize Chiropractic examination, treatment, physiotherapy and rehabilitation as deemed necessary by the doctor.

If a minor child is being treated, the undersigned hereby consents and authorizes the doctor to administer such examination and treatment deemed necessary on the patient.

☐ PERSONAL INJURY/AUTO ACCIDENT PATIENTS

Hatlen Family Chiropractic offers the following billing options for a personal injury or auto accident cases.

Medical Payment (Medpay): _____ (Initial if you select this option)

Hatlen Family Chiropractic will bill the patient's auto insurance if a Medical (Medpay) benefit is available. Patients are responsible for understanding and knowing their benefits with regards to their auto insurance. Patients are also responsible for setting up claims with their insurance company. Medpay Limit: _____

Health Care Provider Lien: _____ (Initial if you select this option)

Hatlen Family Chiropractic will setup a Health Care Provider Lien with the County Records Office, which will notify all parties of the settlement that Dr. Hatlen will be treating you and therefore will need to be paid in full for services rendered. (See "Lien Form")

A. A fee of \$75 will be due up front to setup the lien with the County Records Office.

B. Hatlen Family Chiropractic will wait for settlement as long as the patient stays **active and follows the treatment plan and recommendations**. Patient also agrees to retain an attorney to represent their case.

C. Patient agrees and signs Hatlen Family Chiropractic's "Lien Form"

D. Patient authorizes Hatlen Family Chiropractic to release information regarding care to the patient's attorney and responsible insurance company.

E. If patient suspends or terminates care, all fees are due immediately.

I have read, understand and agree to the terms of this financial policy.

Signed: _____ **Date:** ____/____/____

HATLEN FAMILY CHIROPRACTIC HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Printed Name of Patient or Representative

Signature of Patient or Representative

Date

Dr. Gary C. Hatlen, Hatlen Family Chiropractic, 3842 E. Thunderbird Rd., Ste. 200, Phoenix, AZ. 85032 (602) 443-4423

Hatlen Family Chiropractic

TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation (nerve interference). Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes disturbance of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body’s innate intelligence. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child:

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

Pregnancy Release:

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)

(date)

****COMPLETE THE FOLLOWING PAGES FOR EACH SYMPTOM BEGINNING WITH THE MOST SEVERE SYMPTOM.**

Name: _____ Date: ____/____/____

Symptom: _____

Rate the severity of your symptom on a scale from 1-10, with 10 being the worst pain, please circle the number that best describes the symptom most of the time:

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

What percentage of the time you are awake do you experience the above symptom?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% (Constant)

When did the symptom first begin? _____

Did the symptom begin suddenly or gradually?

How did the symptom begin (cause)? unknown auto accident work injury sports injury mental stress

Explain: _____

What makes the symptom worse? (check all that apply):

nothing bending neck forward bending neck backward tilting head to left tilting head to right turning head to left turning head to right bending forward at waist bending backward at waist tilting left at waist tilting right at waist sitting standing getting up from sitting position lifting any movement driving walking running

other (please describe): _____

What makes the symptom better? (check all that apply):

nothing rest ice heat stretching exercise massage pain medication muscle relaxers

other (please describe): _____

Describe the quality of the symptom: (check all that apply):

sharp dull ache burning throbbing piercing stabbing nagging numb tingling pins and needles

other (please describe): _____

Does the symptom radiate to another part of your body? (check one): No Yes

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (check one)

Morning Afternoon Evening Night Unaffected by time of day

Which of the following activities of daily life are being adversely affected by your symptom?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Housework	<input type="checkbox"/> Job/Work
<input type="checkbox"/> Standing up	<input type="checkbox"/> Running	<input type="checkbox"/> Bending over	<input type="checkbox"/> Cooking	<input type="checkbox"/> Computer work
<input type="checkbox"/> Standing	<input type="checkbox"/> Exercising	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Social life
<input type="checkbox"/> Laying on sides	<input type="checkbox"/> Sports activities	<input type="checkbox"/> Lifting children	<input type="checkbox"/> Yard work	<input type="checkbox"/> Relationships
<input type="checkbox"/> Laying on back	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Playing with kids	<input type="checkbox"/> Driving	<input type="checkbox"/> Finances

What have you tried to achieve relief for this symptom? (check all)

Medical Prescription Drug Over-the-counter Drug Surgery Physical Therapy Other: _____

Results: _____

Any other information? _____

Name: _____ Date: ____/____/____

Symptom: _____

Rate the severity of your symptom on a scale from 1-10, with 10 being the worst pain, please circle the number that best describes the symptom most of the time:

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

What percentage of the time you are awake do you experience the above symptom?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% (Constant)

When did the symptom first begin? _____

Did the symptom begin suddenly or gradually?

How did the symptom begin (cause)? unknown auto accident work injury sports injury mental stress

Explain: _____

What makes the symptom worse? (check all that apply):

nothing bending neck forward bending neck backward tilting head to left tilting head to right turning head to left turning head to right bending forward at waist bending backward at waist tilting left at waist tilting right at waist sitting standing getting up from sitting position lifting any movement driving walking running

other (please describe): _____

What makes the symptom better? (check all that apply):

nothing rest ice heat stretching exercise massage pain medication muscle relaxers

other (please describe): _____

Describe the quality of the symptom: (check all that apply):

sharp dull ache burning throbbing piercing stabbing nagging numb tingling pins and needles

other (please describe): _____

Does the symptom radiate to another part of your body? (check one): No Yes

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (check one)

Morning Afternoon Evening Night Unaffected by time of day

Which of the following activities of daily life are being adversely affected by your symptom?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Housework	<input type="checkbox"/> Job/Work
<input type="checkbox"/> Standing up	<input type="checkbox"/> Running	<input type="checkbox"/> Bending over	<input type="checkbox"/> Cooking	<input type="checkbox"/> Computer work
<input type="checkbox"/> Standing	<input type="checkbox"/> Exercising	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Social life
<input type="checkbox"/> Laying on sides	<input type="checkbox"/> Sports activities	<input type="checkbox"/> Lifting children	<input type="checkbox"/> Yard work	<input type="checkbox"/> Relationships
<input type="checkbox"/> Laying on back	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Playing with kids	<input type="checkbox"/> Driving	<input type="checkbox"/> Finances

What have you tried to achieve relief for this symptom? (check all)

Medical Prescription Drug Over-the-counter Drug Surgery Physical Therapy Other: _____

Results: _____

Any other information? _____

Name: _____ Date: ____/____/____

Symptom: _____

Rate the severity of your symptom on a scale from 1-10, with 10 being the worst pain, please circle the number that best describes the symptom most of the time:

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

What percentage of the time you are awake do you experience the above symptom?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% (Constant)

When did the symptom first begin? _____

Did the symptom begin suddenly or gradually?

How did the symptom begin (cause)? unknown auto accident work injury sports injury mental stress

Explain: _____

What makes the symptom worse? (check all that apply):

nothing bending neck forward bending neck backward tilting head to left tilting head to right turning head to left turning head to right bending forward at waist bending backward at waist tilting left at waist tilting right at waist sitting standing getting up from sitting position lifting any movement driving walking running

other (please describe): _____

What makes the symptom better? (check all that apply):

nothing rest ice heat stretching exercise massage pain medication muscle relaxers

other (please describe): _____

Describe the quality of the symptom: (check all that apply):

sharp dull ache burning throbbing piercing stabbing nagging numb tingling pins and needles

other (please describe): _____

Does the symptom radiate to another part of your body? (check one): No Yes

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (check one)

Morning Afternoon Evening Night Unaffected by time of day

Which of the following activities of daily life are being adversely affected by your symptom?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Housework	<input type="checkbox"/> Job/Work
<input type="checkbox"/> Standing up	<input type="checkbox"/> Running	<input type="checkbox"/> Bending over	<input type="checkbox"/> Cooking	<input type="checkbox"/> Computer work
<input type="checkbox"/> Standing	<input type="checkbox"/> Exercising	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Laundry	<input type="checkbox"/> Social life
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<input type="checkbox"/> Laying on back	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Playing with kids	<input type="checkbox"/> Driving	<input type="checkbox"/> Finances

What have you tried to achieve relief for this symptom? (check all)

Medical Prescription Drug Over-the-counter Drug Surgery Physical Therapy Other: _____

Results: _____

Any other information? _____

Name: _____ Date: ____/____/____

Symptom: _____

Rate the severity of your symptom on a scale from 1-10, with 10 being the worst pain, please circle the number that best describes the symptom most of the time:

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

What percentage of the time you are awake do you experience the above symptom?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100% (Constant)

When did the symptom first begin? _____

Did the symptom begin suddenly or gradually?

How did the symptom begin (cause)? unknown auto accident work injury sports injury mental stress

Explain: _____

What makes the symptom worse? (check all that apply):

- nothing
- bending neck forward
- bending neck backward
- tilting head to left
- tilting head to right
- turning head to left
- turning head to right
- bending forward at waist
- bending backward at waist
- tilting left at waist
- tilting right at waist
- sitting
- standing
- getting up from sitting position
- lifting
- any movement
- driving
- walking
- running

other (please describe): _____

What makes the symptom better? (check all that apply):

- nothing
- rest
- ice
- heat
- stretching
- exercise
- massage
- pain medication
- muscle relaxers

other (please describe): _____

Describe the quality of the symptom: (check all that apply):

- sharp
- dull ache
- burning
- throbbing
- piercing
- stabbing
- nagging
- numb
- tingling
- pins and needles

other (please describe): _____

Does the symptom radiate to another part of your body? (check one): No Yes

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (check one)

- Morning
- Afternoon
- Evening
- Night
- Unaffected by time of day

Which of the following activities of daily life are being adversely affected by your symptom?

- | | | | | |
|--|--|--|------------------------------------|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Walking | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Housework | <input type="checkbox"/> Job/Work |
| <input type="checkbox"/> Standing up | <input type="checkbox"/> Running | <input type="checkbox"/> Bending over | <input type="checkbox"/> Cooking | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Exercising | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Laundry | <input type="checkbox"/> Social life |
| <input type="checkbox"/> Laying on sides | <input type="checkbox"/> Sports activities | <input type="checkbox"/> Lifting children | <input type="checkbox"/> Yard work | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Laying on back | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Playing with kids | <input type="checkbox"/> Driving | <input type="checkbox"/> Finances |

What have you tried to achieve relief for this symptom? (check all)

- Medical
- Prescription Drug
- Over-the-counter Drug
- Surgery
- Physical Therapy
- Other: _____

Results: _____

Any other information? _____

*****PLEASE REQUEST MORE SYMPTOM FORMS IF NECESSARY**