PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs.
If you have any questions, do not hesitate to ask for assistance. We will be happy to help.

Today's Date: ___ / ___ / ___ Sex: ☐ Male ☐ Female
Name: _____ SS#: _____
Address: _____ Birthdate: ___/___/___
City, State, Zip: _____ Home Phone: _____
Where do you prefer to receive calls? _____ Work Phone: _____
Your employer: _____ Cell Phone: _____
Occupation: _____ Email: _____

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Person to contact in case of emergency: _____ Phone: _____
Primary care physician: _____ Phone: _____
Whom may we thank for referring you to us? _____

** If this is a workman's compensation case or a motor vehicle accident, please stop and inform the receptionist.*

RESPONSIBLE PARTY

Name of person responsible for this account: _____
Address: _____ Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to Patient: _____

Notice: All first visit charges are payable when services are rendered. We accept cash, check, visa, or mastercard. This office will *verify* insurance coverage for you. This is done as a courtesy for you, so please make sure to complete the area below and provide a copy of your insurance card.

INSURANCE INFORMATION

Name of Company: _____ Phone #: _____
Name of Insured: _____ Insured's Birthdate : ___ / ___ / ___
Patient's relationship to Insured: _____ Name of Plan: _____
Group #: _____ I.D. #: _____

Name of Company: _____ Phone #: _____
Name of Insured: _____ Insured's Birth Date: ___ / ___ / ___
Patient's relationship to Insured: _____ Name of Plan: _____
Group #: _____ I.D. #: _____

AUTHORIZATION AND RELEASE: *I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.*

Patient's or Guardian's Signature: _____ Date: ___ / ___ / ___

CHIEF COMPLAINT

Have you ever had chiropractic treatment before? ☐Yes ☐No If yes, when was your last visit? _____
Reason(s) for today's visit: _____
_____
When (month and year at least) did you first notice the symptoms? : ___ / ___ / ___

Is the condition getting progressively worse? ☐ Yes ☐ No
Where specifically is the problem located? _____

Difficult Activities: ☐ Sitting ☐ Lying Down ☐ Standing ☐ Walking ☐ Bending ☐Other _____

Type of Pain: ☐ Throbbing ☐ Dull ☐ Sharp ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramping ☐ Swelling ☐ Other: _____

Rate the severity of your complaint: 1 2 3 4 5 6 7 8 9 10 Is the pain ☐ Constant ☐ Intermittent

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy
☐ Other _____

MEDICAL CASE HISTORY

HEALTH HISTORY

Please check all that apply to you:

___ AIDS/HIV	___ ADD/ADHD	___ Allergy/Sinus Problems	___ Appendicitis
___ Arthritis	___ Asthma	___ Bleeding Disorders	___ Bed-wetting
___ Cancer	___ Carpel Tunnel	___ Chronic Fatigue Syndrome	___ Depression
___ Diabetes	___ Digestive Disorders	___ Ear Infections	___ Emphysema
___ Epilepsy	___ Female Complications	___ Fibromyalgia	___ Glaucoma
___ Gout	___ Headaches	___ Heart Disease	___ Hernia
___ Herniated Disc	___ High Blood Pressure	___ High Cholesterol	___ Kidney Disease
___ Liver Disease	___ Migraines	___ Multiple Sclerosis	___ Osteoporosis
___ Parkinson's Disease	___ Pinched Nerve	___ Prostate Problems	___ Prosthesis
___ Rheumatoid Arthritis	___ Scoliosis	___ Stroke	___ Thyroid problems
___ TMJ Dysfunction	___ Tumors, growths	___ Ulcers	___ Vertigo

___ Other _____

List surgeries, serious illnesses, falls, and auto accidents (include dates): _____
_____
_____
List all known allergies: _____
Have you been treated by a physician for any health condition in the past year? _____ If yes, please explain _____
_____
Please list all medications, vitamins, and supplements that you take. _____
_____
_____

Women: Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

FAMILY HISTORY

Please check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother:

___Tuberculosis	___Cancer	___Mental Illness	___Diabetes
___Asthma	___Heart Disease	___Stroke	___Kidney Disease
___Lung Disease	___Arthritis	___Liver Disease	___Other _____

SOCIAL HISTORY

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

☐ Computer work ☐ Other: _____

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____
How much alcohol do you consume on a weekly basis? _____
How much caffeine do you consume on a weekly basis? _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Complete Chiropractic, P.C., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient's or Guardian's Signature: _____Date: ____ / ____ / ____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractic Physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: ___ / ___ / ___

FINANCIAL POLICY

A detailed, estimated cost of care will be provided for you after the doctor's report of findings is given, and any questions that you have will be addressed at that time as well. All payments are due at the time of service unless other arrangements are made.

Payment at Time of Service or Weekly. For our patients without insurance, we will offer a 20% discount when payment is made by Cash, Check, Visa, or Mastercard at the time of service, or to those who pay the full amount weekly by signing a credit card guarantee form. Service men and women and immediate family members will be given a 25% discount with valid I.D.

Payment Plan. We offer two types of payment plans. In-house plans require a credit card guarantee and must be paid within six months. In-house payment plans do not qualify for the 20% time of service discount. We are also able to set up flexible low monthly payment plans spread out over a longer period of time with no up-front costs through Care Credit. They offer low rates and a number of interest-free options. Care Credit payment plans qualify for the 20% time of service discount unless being used to cover co-payments or deductibles.

Group or Individual Insurance. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. We encourage you to check your benefit packet too, as we are not responsible for any mistakes quoted by your insurance company to us. As a courtesy to you, we will file all necessary forms with your insurance company. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-payments. We will also offer insurance patients the 20% Time of Service reduction in fees should you decide to pay the full amount due at each visit and submit the bill to your insurance yourself. **All co-payments and deductibles are due at the time of service unless you authorize a credit card guarantee.**

Flex Plans/Medical Savings Accounts. Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Medicare. We do accept assignment from Medicare. The check is usually sent directly to our office in payment of services that Medicare will cover which for Chiropractors is **ONLY manual manipulation of the spine**. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services such as x-rays, examinations, therapies, and supports **are not covered**. Please notify us if you have a Medicare supplement or replacement policy.

Worker's Compensation. If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due immediately.

I have read and understand the financial policy of Complete Chiropractic, P.C.. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Complete Chiropractic and my insurance company. I will notify Complete Chiropractic immediately if there are any changes to my insurance company and/or benefits.

Patient's Signature: _____ Date: ___ / ___ / ___

Authorization for Radiology Interpretation Services

I understand that any x-rays taken at or supplied to Complete Chiropractic P.C. will be referred to a board certified radiologist at Crossroad Radiology for interpretation. I hereby authorize my doctor to send x-rays/medical records to Crossroad Radiology for interpretation, and I agree to pay $35 to Crossroad Radiology for this service at the time x-rays are taken. I understand this fee is for interpretation only and is in addition to any fees that are charged by Complete Chiropractic, P.C. for taking the x-rays. I will be provided with an itemized statement for this service upon receipt of interpretation report to seek reimbursement from my insurance company.

_____ _____ / _____ / _____

Patient's Printed Name Patient's DOB

_____ _____ / _____ / _____

Patient's or Guardian's Signature Date

_____

Guardian's Printed Name Relationship to Patient