

PATIENT NAME: _____ DATE: _____

Chiropractic Case History/Patient Information

Name: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone: Home: _____

Age: _____ Birth date: _____ Race: _____ Cell: _____

Marital: M S W D Can we leave a message on the #'s listed above? Yes No

Occupation: _____ Employer: _____

Employers Address: _____ Office phone: _____

Spouse: _____ Occupation/Employer: _____

Names and Ages of Children: _____

Name of nearest relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor? _____ Do we have your permission to inform your doctor regarding your care at this office? _____

History of Present Illness:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or date of accident: _____

Is this due to: Auto ___ Work ___ Other _____

Have you ever had the same or similar condition? Yes No If yes, when and describe:

Days lost from work: _____ How did you treat it? _____

Date of last physical exam? _____

What do you hope to get out of your Chiropractic visit(s)? _____

Past Medical History:

Have you ever been diagnosed as having or have suffered from: (Place a check mark by conditions that apply to you)

___ Broken or Fractured Bones ___ Osteoarthritis ___ Eating Disorder ___ Stroke

___ Circulatory Problems ___ Epilepsy ___ Alcoholism ___ Cancer

___ Rheumatoid Arthritis ___ Pace Maker ___ Drug Addiction ___ Gall Bladder

___ Seizures/Convulsions ___ HIV Positive ___ Ruptures ___ Congenital Disease

___ Excessive Bleeding ___ Depression ___ Coughing Blood ___ Ulcers

___ High/Low Blood Pressure

PATIENT NAME: _____ DATE: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (including dates): _____

Have you been treated for any health condition by a physician in the last year: Yes No If yes, please describe what and the outcome: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications or latex? Yes No If yes, describe _____

Do you have any allergies of any kind? Yes No If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

Is there anything you feel we should know about you &/or your condition? _____

Social History:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day _____

Do you take vitamin supplements? _____ If so, please list _____

Do you consume caffeine? _____ If so, how much per day _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What percentage of time during the day (at home or at your job) do you spend

Lifting _____ Sitting _____ Bending _____ Working at at computer _____

Family History

Parents:

Father: Living ___ Deceased ___ Current age if living: ___ Cause of death and age at death if deceased: _____

Mother: Living ___ Deceased ___ Current age if living: ___ Cause of death and age at death if deceased: _____

If applicable: ___ Adopted as a child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

PATIENT NAME: _____ DATE: _____

Family Diseases (check if applicable and indicate whether family member is Father, Mother, Sister, Brother)

Tuberculosis___ Cancer___ Mental Illness___ Diabetes___
Asthma___ Heart Disease___ Stroke___ Kidney Disease___
Lung Disease___ Arthritis___ Liver Disease___ Other_____

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical Workers Compensation Medicare Auto Accident
 Medical Savings Account & Flex Plan Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, 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 or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel 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, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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.

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 Signature _____ Date _____

Office Use Only

- 1
- 4-5
- >5

Patient #: _____

Pain Drawing

Name: _____

Date: _____

Date of Birth: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>

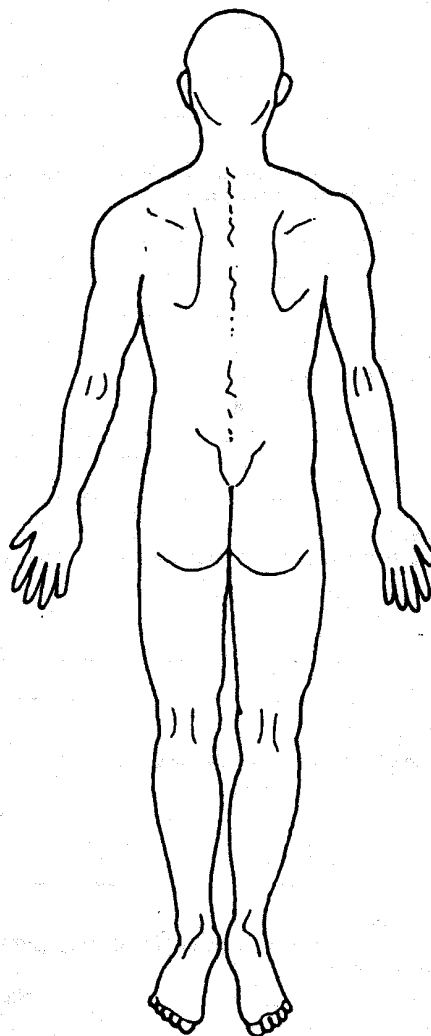
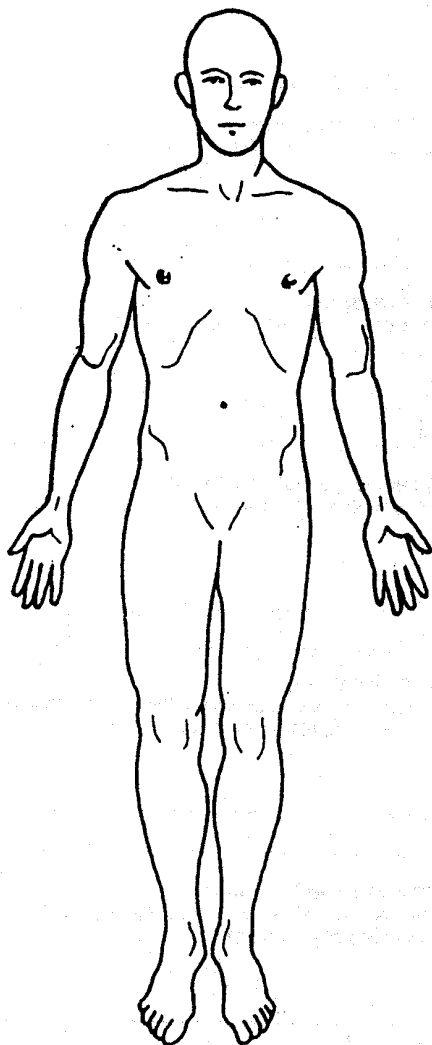
Burning x x x x

Numbness = = = = =

Stabbing // // // //

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~



Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare___ Medicaid___ Champus___ CampVA___
Group Health Plan___ Other___ Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
- City_____ State_____ Zip_____ Tel #_____
5. Insured's Address (if same as patient put "same"):_____
- City_____ State_____ Zip_____ Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
- Other Insured's Policy or Group Number:_____
- Other Insured's Date of Birth:_____ Male_____ Female_____
- Employer's Name or School Name:_____
- Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes___ No___
9. Is the condition we are treating related to an auto accident? Yes___ No___
10. Is the condition we are treating related to another type of accident? Yes___ No___
11. Insured's Policy Group or FECA Number:_____
- Insured's Date of Birth:_____ Male_____ Female_____
- Employer Name or School Name:_____
- Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes___ No___

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___ No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes___ No___
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___ Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

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 Patient Health Information 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 Patient Health Information (**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.

Name of Patient

Date

Advanced Health Chiropractic **FINANCIAL POLICY**

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount. Your balance may **never exceed \$250.00** at any time unless you have been **set UP** on a payment plan.

GENERAL INSURANCE: As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees. We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

Your obligation is to pay any and all deductibles and co-payments as you go. You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office within five working days of your initial visit. Failure to do so will make you a cash patient and payment in full will be required on day five. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, in your state, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office within 5 working days of your initial visit. Failure to do so will make you a cash patient and payment in full of any outstanding balance will be required on day five. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

PATIENT SIGNATURE: _____

PRINTED NAME: _____

DATE: _____