Marital Status Sex Date of Birth Age

Patient Name:_____ S M W D SEP. M/F ___/____/____ ____

Last First MI

Patient Address: _____

Street City State Zip

Phone: Home: (____)_____ Cell: (____)_____ Work: (____)_____

Email: _____

Occupation:_____

Employer:_____

Emergency Contact:_____

Relationship:_____

Emergency Contact Phone: (___)_____

How did you hear about us?

- ☐ Referral
  - Who can we thank?_____
- ☐ Website
- ☐ Internet Search
- ☐ Sign / Drive by

Insurance Company: _____ Insurance Subscriber's Name: _____

Relationship to Subscriber: _____ Insurance Subscriber's Date of Birth: _____

Medical Doctor:_____ Doctor Phone:_____

Is the condition related to an auto accident or work accident? Yes:___ No:___ Date of accident:____/____/_____

Describe the reason for your visit:_____

_____

Date of Injury/Date symptoms first appeared: ____/____/_____

Is the pain: ____ Constant ____ Intermittent ____ Occasional ____ Rare

Have you had other treatment for this condition? Yes:___ No:____ If yes, describe:_____

Have you had X-RAYS or MRI recently taken? Yes:____ No:_____ If yes, where?_____

List of current medications you are taking:_____

_____

Smoking? Yes:___ No:____ Alcohol use: Yes:____ No:____ Occasionally:____

Previous Surgeries/Fractures/Injuries: _____

_____

We are a training facility for Logan Chiropractic College and frequently have interns/residents assisting our doctors. If you oppose having an intern in the room, please notify your doctor.

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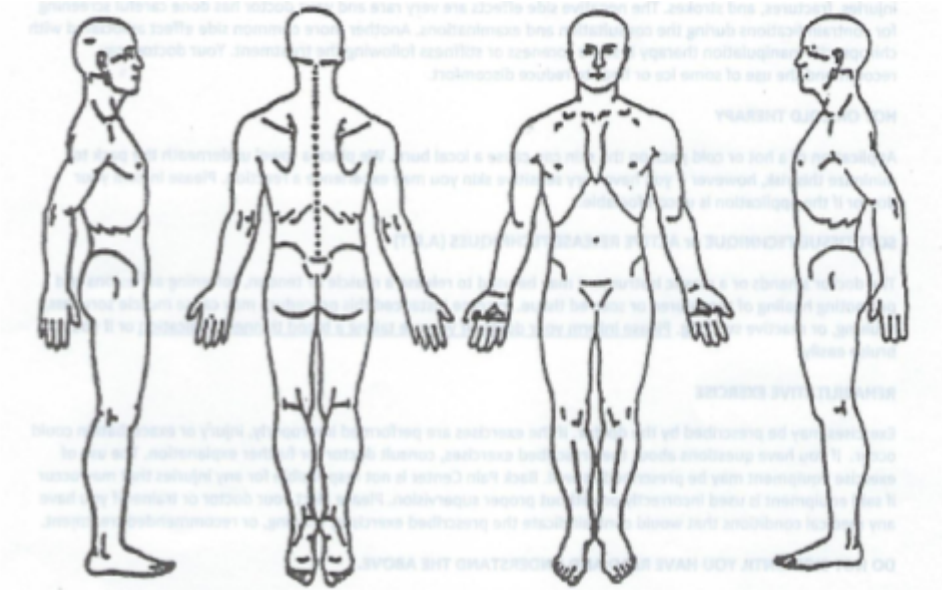
PAST MEDICAL HISTORY	SELF	FAMILY	PAST MEDICAL HISTORY	SELF	FAMILY
Heart Disease			Asthma		
High Blood Pressure			Emphysema		
Stroke			DVT		
Rheumatic Fever			Hepatitis C		
Lung Problems			Hiatal Hernia		
Diabetes			Epilepsy/Seizures		
Cancer			**REVIEW OF SYMPTOMS**		
-What part of body?			Chest Pain		
Ulcers			Shortness of Breath		
Vascular Problems			Easy or Prolonged Bleeding or Bruising		
Kidney Disease			Nervous Disorders		
Bladder Infection			Prostate Trouble		
Rheumatoid Arthritis			Urinary Frequency		
			Blood Clots		
			PREGNANCY – FEMALES ONLY	**YES**	**NO**
			Are you pregnant?		
			If, yes how far along?		

CIRCLE ALL AREAS OF PAIN



Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.hhs.gov/ocr/privacy/.

1. The patient understands and agrees to allow this office to use the PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Patient Name:_____ Patient or Parent Signature:_____ Date:_____

CONSENT TO CHIROPRACTIC TREATMENT

THE MATERIAL RISKS INHERENT TO YOUR TREATMENT

Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatments present the risk of complications or negative side effects. The list below includes the various treatments available in our office and the potential risks associated with these treatments.

CHIROPRACTIC MANIPULATION THERAPY

The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. The negative side effects are very rare and your doctor has done careful screening for contraindications during the consultation and examinations. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment. Your doctor may recommend the use of some ice or heat to reduce discomfort.

HOT OR COLD THERAPY

Application of a hot or cold pack on the skin can cause a local burn. We place a towel underneath the pack to minimize this risk, however if you have very sensitive skin you may experience a reaction. Please inform your doctor if the application is uncomfortable.

SOFT TISSUE TECHNIQUE or ACTIVE RELEASE TECHNIQUES (A.R.T)

The doctor's hands or a plastic instrument may be used to release a muscle or tendon, softening adhesions and promoting healing of the injured or scarred tissue. In some instances this procedure may cause muscle soreness, bruising, or reactive swelling. Please inform your doctor if you are taking a blood thinner medication or if you bruise easily.

REHABILITATIVE EXERCISE

Exercises may be prescribed by the doctor. If the exercises are performed improperly, injury or exacerbation could occur. If you have questions about the prescribed exercises, consult the doctor for further explanation. The use of exercise equipment may be prescribed as well. Back Pain Center is not responsible for any injuries that may occur if said equipment is used incorrectly or without proper supervision. Please alert your doctor or trainer if you have any medical conditions that would contraindicate the prescribed exercises, training, or recommended treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic manipulation and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or, in the case of a minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____

Patient Name: _____

Signature of **Patient OR Parent** of minor: _____

DOCTOR SIGNATURE: _____

Flip over for pg. 4

FINANCIAL POLICY

Welcome to Back Pain Center. We ask that you read and sign our financial policy prior to any treatment. To avoid misunderstandings, please ask us if you have questions about our policies.

PAYMENT FOR SERVICE: Our policy requires payment for services at the time service is provided. If special arrangements are needed, please discuss those arrangements with your doctor or the Front Desk prior to treatment.
*Our office accepts cash, personal checks, MasterCard, VISA, Discover, and American Express.
Returned checks will be subject to a $25 fee. We do not accept temporary or post-dated checks.

NON-INSURED: If you do not have insurance or our office is not a participating provider with your insurance plan, the self-pay rate is due at the time of service.

HEALTH/MEDICAL INSURANCE: As a courtesy to you, our office will attempt to contact your insurance company to verify coverage and benefits. It is your responsibility to be aware of your *CHIROPRACTIC* benefits and any policy limitations or changes as your insurance policy is an agreement between you and your insurance company, not between your insurance company and this practice. With the information we receive, we will ***ESTIMATE*** your out-of-pocket cost at the time of your appointment and file your claims; however, we ***CANNOT*** guarantee how the insurance company will process your claim. Once your claim has been processed, you will be sent a statement for any difference in the amount paid and the actual amount due. If your insurance company denies a claim for any reason or you feel your claim was processed incorrectly, you will be required to pay for services and seek reimbursement from your insurance company.

OVERPAYMENTS: In the event we overestimate your out-of-pocket expense resulting in a credit on your account, our office will automatically issue a refund if the patient overpays by $100.01 or more. If the patient overpays by $100.00 or less, our office will make the credit available for future services provided by Back Pain Center unless the patient makes a request for reimbursement. Patient credits will be reviewed once a month for patients who have not been active for 200 days or more.

PATIENTS WITH MEDICARE: Some chiropractic procedures are not billable expenses to Medicare. We will provide an Advanced Non-Covered Beneficiary Notice for your review and signature. We ask you to provide your Medicare information and we will submit your claim.

PERSONAL INJURY/AUTO ACCIDENTS: You will receive an additional Financial Agreement that explains your options and how your medical bills will be handled for each. Regardless of what option you choose, your signature below confirms you understand you are ultimately responsible for payment of the services rendered to you. If you discontinue treatment prior to the doctor releasing you from care, payment of your account becomes due immediately. It is imperative for you to maintain good communication and timely correspondence with all parties involved to help your case settle as quickly as possible.

WORKER'S COMPENSATION: If you are injured on the job, your care should be paid for under your employer's Workers Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their Worker's Compensation insurance carrier. Worker's Compensation will only pay for chiropractic care when authorized by your employer, the insurance carrier, or the Missouri Division of Workers' Compensation (MODWC). We will NOT begin treatment until we have an Authorization of Coverage from your employer's Workers Compensation insurance. If you do not want to wait, you may pay in full at the time services are rendered, until coverage is authorized. We will provide you with a receipt so that you may request compensation from the company yourself.

MISSED APPOINTMENTS: We require a 24-hour notice when canceling or rescheduling an appointment. A $25 fee may be assessed if appointments are missed (or rescheduled) without the proper notice.

COLLECTION FEES: In the event of non-payment, you will be responsible for any reasonable collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance and will be added to the account if it is turned over to an outside agency.

I have read all the above terms and hereby assume responsibility for paying any charges according to these terms. I authorize my insurance company to pay my benefits directly to Back Pain Center.

Patient Name (print): _____ Date: _____

Signature of Patient ***or*** Legal Guardian/Parent: _____

Name of Legal Guardian/Parent (print): _____

BACK PAIN CENTER

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Back Pain Center to release my records and any information requested to the following individuals.

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:**_____
4. _____ **Relation to Patient:**_____

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature