chiropractic

remove obstacles • restore function • improve performance • maximize potential

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

_____
patient or guardian signature

_____
date

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Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT CONTACT

last name	first name	m.i.

preferred to be called

street

city	state	zip

home phone	mobile phone

work phone	e-mail

2 PATIENT PERSONAL

age	date of birth	social security #	sex ☐ male ☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone

relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.

employer name

work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation

street

city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date

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Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	social security #	sex
			☐ male ☐ female

Are you here because you were involved in a vehicle collision? ☐ yes ☐ no

Are you here because you were injured at your place of employment? ☐ yes ☐ no

Are you here because you were involved in another type of accident? ☐ yes ☐ no

Who is responsible for this account?

Will you be using health insurance to supplement payment to our office*? ☐ yes ☐ no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

2 INSURANCE COVERAGE

type of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Workers' Compensation ☐ TRICARE/CHAMPUS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins ID#	primary ins group#
secondary insurance company	**secondary ins ID#**	**secondary ins group#**

3 INSURED INFORMATION

Are the insured and patient the same person? ☐ yes ☐ no If YES, do not complete section 3.

last name	first name	m.i.

street

city	state	zip

age	date of birth	social security #	sex
			☐ male ☐ female

relationship to insured ☐ spouse ☐ dependent ☐ Other _____

We are here to service our patients the best way we know how. We understand the value of health insurance. However, because health insurance plans are intended only to supplement out of pocket expenses for care, it may not cover all the care you need. We will verify your applicable insurance benefits and report the supplemental coverage to you.

Our relationship is with each patient individually, not the insurance companies. If we believe that we may be able to help you and we accept your case, our recommendations will be based on what we believe is best for you - supported by our experience. We take great care in making our services affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges before the associated procedure or service is performed
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred from services rendered

patient or guardian signature

date

1 BENEFITS ASSIGNMENT

I authorize that payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

patient or guardian signature _____ date _____

2 INFORMATION RELEASE

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

patient or guardian signature _____ date _____

INSURANCE VERIFICATION

OFFICE USE ONLY – Please Do Not Write In This Box

Is this a **Workers' Comp** case? ☐ yes ☐ no

Has the injury been reported? ☐ yes ☐ no

Name:

Title:

Is patient currently employed at place of injury? ☐ yes ☐ no

Name of person authorizing care:

Is this an **Auto Collision** or **Personal Injury** case? ☐ yes ☐ no

Has it been reported to the insurance company? ☐ yes ☐ no

Has an application for benefits been filed? ☐ yes ☐ no

Did the police write a report? ☐ yes ☐ no

Is auto or PI insurance primary? ☐ yes ☐ no

Agent name and contact info:

Does the plan cover the following services?

- chiropractic adjustments ☐ yes ☐ no
- modalities:
  - hot/cold packs ☐ yes ☐ no
  - mechanical traction ☐ yes ☐ no
  - electric stimulation ☐ yes ☐ no
  - ultrasound ☐ yes ☐ no
- therapeutic exercise and activities ☐ yes ☐ no
- neuromuscular re-education ☐ yes ☐ no
- massage ☐ yes ☐ no
- manual therapy technique ☐ yes ☐ no
- exams ☐ yes ☐ no
- supports, braces, collars ☐ yes ☐ no
- pillows ☐ yes ☐ no
- nutritional supplements ☐ yes ☐ no
- orthotics ☐ yes ☐ no
- other:_____ ☐ yes ☐ no
- other:_____ ☐ yes ☐ no

Does the plan have a deductible? ☐ yes ☐ no

- Amount for an individual:
- Amount for the family:
- Amount currently met:
- When does the deductible renew?
- Do charges for diagnostic tests apply to the deductible?

What is the co-pay after the deductible is met?

What is the maximum yearly benefit?

What is the yearly visit cap?

Does the company assign benefits to the doctor? ☐ yes ☐ no

Are any special forms required to file claims? ☐ yes ☐ no

What is the name of the person that you spoke with?

Last:

First:

ID# Extension:

Notes:

PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Other_____
- ☐ Other_____

Has this child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____