

Date: _____

Confidential Patient Information

Patients Name: _____	Chief Complaint: _____
Address: _____	Home Phone: _____
City: _____ Zip: _____	Cell Phone: _____
SS#: _____	Email: _____
Date of Birth: _____	Marital Status: M S W D
Occupation: _____	Employer: _____
Address of Insured (if different than above): _____	

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes No

Ins. Company: _____	Ins. Phone #: _____
ID#: _____	Group #: _____
Name of Policy Holder: _____	Policy Holder DOB: _____
Policy Holders Employer: _____	

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? _____

How did you hear about our office? _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Booher Family Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

Patient Name: _____

Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment 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 care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor 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 regimen. I understand that if I am accepted as a patient by a physician at **Booher Family Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request.

Missed Appointments:

All missed appointments without 24 hour notice of cancellation will incur a \$25 fee.
Any nutrition appointment that is not cancelled 24 hours prior to scheduled appointment will be charged \$45-\$90.

Consent to Evaluate and Treat a Minor:

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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Name: _____ Relation: _____

Name: _____ Relation: _____

May we leave messages regarding your personal healthcare information on any answering device i.e. home answering machines or voicemails? Yes [] No []

Acknowledgement:

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Financial Policy

- 1.) According to your insurance plan you are responsible for any and all **co-payments, deductibles, and coinsurances.**
- 2.) **Copayments** are due at the time of service.
- 3.) **Self-pay** patients are expected to pay for services in **FULL** at the time of the visit.
- 4.) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB). Your payment is due within 30 business days after the receipt of your statement.
- 5.) Balances are to be collected at your scheduled appointment or upon receipt of your statement; whichever comes first. Unless a monthly payment plan has been set up with our office your account cannot accrue more than a \$100 balance. If this occurs, appointments will be postponed until payment is made.
- 6.) If previous arrangements have NOT been made with our office regarding a payment plan, any account balance outstanding after 90 days will be forwarded to a collection agency.
- 7.) We accept cash, checks, and most major credit/debit cards. Payments can be called in by phone, made in person, or mailed into the office.
- 8.) A \$35 fee will be charged for any checks returned for insufficient funds.

Signed: _____

Date: _____

Printed: _____