Angell Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Name ______________________________ Sex __________ Marital Status ________ DOB ______________ Age ________

Nickname or name you preferred to be called ____

Address ______________________________ City ______________ State ________ Zip Code __________

Home Phone __________________ Cell Phone __________________ Work Phone ____________________

Email Address ____

Would you like appointment reminders? Email ☐ Yes ☐ No Text Message ☐ Yes ☐ No If yes, phone carrier: __________

Employer ______________________________ Occupation ______________________________

Spouse (if applicable)__________________________ Spouse's Employer ____________________________

Emergency Contact ________________________ Relationship ________________ Phone ______________

Do you have insurance? (circle) Yes No If yes, please provide front desk with copy of insurance card(s)

Who referred you to, or how did you hear about, our office?____

On a scale from 0-10 how would you rate your current health? ____________________________________

Is your visit due to an accident? (circle) Yes No (If yes, please see front desk for an injury report)

Your present complaints/symptoms ____

List other doctor(s) seen for this condition ____

Personal Medical history (if any of the following are relevant to your medical history, please circle all that apply)

Cancer	Muscular	Rheumatic Fever	Digestive Disorders	Diabetes
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Hepatitis
Tuberculosis	Convulsions	Nervousness	Backaches	German Measles
High Blood Pressure	Epilepsy	Asthma	Numbness	Venereal Disease
Heart Trouble	Concussion	Dizziness	Arthritis	

Have you ever had chiropractic care? (circle) Yes No Date of last adjustment __________________

Have you ever had massage therapy? (circle) Yes No Date of last massage ____________________

Describe any operations you've had and the dates: ____

Have you been treated by a physician for any health conditions in the last year? Yes No

Describe condition ________________________________ Date of last physical exam __________________

Are you now taking any medication? (circle) Yes No What Kind? __________________________________

What supplements/vitamins are you currently taking? ____

Are you pregnant? (circle) Yes No Date of last menstrual period ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Angell Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Angell Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's Signature ______________________________________ Date ____________________

Printed name if signed on behalf of patient ____________________________ Relationship ______________

Angell Chiropractic

OFFICE POLICY

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage

Complimentary Consultation: Angell Chiropractic will conduct a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy: We feel the patient's health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services: Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker's Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance: Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Angell Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Angell Chiropractic will be credited to your account upon receipt.

Appointments: To better serve our patients, we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else.
Please call our office as soon as possible if you are not going to make your scheduled appointment.

Identification Policy: Angell Chiropractic requires a copy of photo identification (ex: driver's license, passport, student ID) be on file in order to receive care. Also, we require an electronic photo be taken and placed into your medical chart for verification purposes.

Questions and Answers: Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Angell Chiropractic clinic policies and agree to honor them:

Patient's Signature ____ **Date** _________________________

Printed name if signed on behalf of patient _________________________________ **Relationship** ______________

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PRIVACY PRACTICES AND RELEASES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Angell Chiropractic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

You may refuse to sign this acknowledgement

By my signature below I acknowledgement receipt of the Notice of Privacy Practices

____
Patient's signature Date Time

____
Printed name if signed on behalf of patient Relationship

FOR OFFICE USE:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) ____

Additional Disclosure Authority
In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Name: Relationship:

____

____

Our doctors take your healthcare seriously and find it extremely important to keep your primary care provider up to date on your care in our offices. Please provide us with the name and location of your PCP and we will send them your current exam findings and any other requested information.

Primary Care Provider: ____

Location/Office: ____

____
Patient's signature Date

____
Printed name if signed on behalf of patient Relationship

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INFORMED CONSENT

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, cold application and manual muscle therapy) are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are very small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are **extremely** rare and their association with spinal adjustments (manipulation) is debated. These complications include: injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs and spinal fractures. *I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.*

Patient's Signature ____ Date _________________

Printed name if signed on behalf of patient ___________________________________ Relationship _______________

Authorization To Treat A Minor:

As a parent or legal guardian, I hereby authorize treatment of the following Individual for any chiropractic treatment deemed advisable. I also give permission to perform chiropractic treatment if a parent or legal guardian is not available when the child is brought in for treatment.

Patient's Full Name ____ Date of Birth ________________

This authorization will be effective as of __________________________
Date

Parent or Legal Guardian:

Signature ______________________________________ Print Name ______________________________

Witnessed by___________________________________ Print Name ______________________________

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NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the service provided to you for the following reasons:

That the particular service is not reasonable and necessary under my insurance companies standards.

For this reason, please read and sign the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services."

Patient's Signature Date

Printed name if signed on behalf of patient Relationship

ASSUMPTION OF FINANCIAL RESPONSIBILITY

****Explanation of benefits disclaimer****

I, the undersigned patient, completely understand that Angell Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Angell Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Angell Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Angell Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file" to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic.

I understand that Angell Chiropractic may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Patient Signature's Date

Printed name if signed on behalf of patient Relationship