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 health with your family, thank you for referring other patient's to us.

We may use your health information for health and safety reasons, reporting to law officials, reporting victims of abuse, court hearings and filings and reporting to worker's compensation.

You have a 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, request confidential communication, amend your protected health information and advise our management if you believe your privacy rights have been violated.

These privacy practices are effective: ____________________

For further information, please contact Tami Blondo, our privacy officer at 793-5555.

___ I do not want my public health information shared with anyone other than myself.

___ I only want my next of kin to have access to my public health information: _____________________
____

___ I only want my public health information shared with the following person(s): __________________
____

Password for the account: ___________________ (your mother's first name).

Dated: _____________________ Signature of Patient: ___________________________________

Witness: ________________________ Signature of Guardian: _________________________________

Patient Registration

Patient Contact:
Last Name: ________________________________ First Name: _____________________________
Address: ____
City: ____ State: ______ Zip Code: ________________
Home Phone: _____________________________ Cell Phone: _____________________________
Work Phone: ______________________________ Email: __________________________________
Date of Birth: ______________________________ Sex: ___ Male ___ Female
Status: ___ Single ___ Married ___ Partnered ___ Widowed ___ Separated ___ Divorced
Employer: ____
Address: ____

Emergency Contact:
Name: ____________________________________ Home Phone: ___________________________
Relationship: _______________________________ Other Phone: ____________________________

Spouse or Guardian:
Last Name: _________________________________ First Name: _____________________________
Date of Birth: _______________________________ Work Number: __________________________
Employer: ____
Address: ____

Insurance Information:
Primary Insurance: ____
Primary Insurance ID No.: _____________________________ Group No.: ________________
Insured: ___________________________________ Date of Birth: _____________________________
Relationship to Insured: ______________________

Secondary Insurance: ____
Secondary Insurance ID No.: _____________________________ Group No.: ________________
Insured: _____________________________________ Date of Birth: ___________________________
Relationship to Insured: _______________________

Account Information

Patient Name:
Last Name: _____________________________________ First Name: _______________________
Date of Birth: ______________________ Age: ____ Sex: ___ Male ___ Female

Are you here because you were involved in an automobile accident?: ___ Yes ___ No
Are you here because you were injured at work?: ___ Yes ___ No

Insurance Verification
(Office Use Only – Do Not Complete)

Is this a Worker's Compensation Case? Yes No
Has the injury been report? Yes No
Name: ____
Title: ____
Is the patient currently employed at place of injury? Yes No
Name of Person Authorizing Care: _________________________
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 & Activities Yes No
Neuromuscular Re-Education Yes No
Massage Yes No
Manual Therapy Technique Yes No
Exams Yes No
Supports, braces, collars, pillows Yes No
Nutritional Supplements Yes No
Orthotics Yes No
Other: ____________________________ Yes No

Is this an Auto Collision? Yes No
Is this a Personal Injury? 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: ____
Contact Information: ____________________________________

Does the plan have a deductible? Yes No
Amount for Individual: ___________________________________
Amount for the family: ___________________________________
Amount Currently Met: ___________________________________
When does the deductible renew? __________________________
Do charges for diagnostic tests apply to deductible? Yes No
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
Name of Person Spoke with: ______________________________________
Phone and Extension: ____
Name of Company: ____

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: _____________________________________ Dated: ________________

BENEFITS ASSIGNMENT:

I authorize that payment of charges be made directly to the doctor 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: ____ Dated: ______________

INFORMATION RELEASE:

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

Patient or Guardian Signature: _______________________________________ Dated: _______________

Patient Case History

Patient Information:

Last Name: _______________________________________ First Name: ______________________

Health Complaints:

Are you here because you were injured while working, in a motor vehicle accident or in another accident? Yes No

What Services Are You Interested In? (Mark all that apply)

___ Injury Prevention
___ Treatment for Pain
___ Spinal/Body Alignment
___ Range of motion, mobility or flexibility Therapy
___ Strengthening Exercises
___ Nutritional/Supplement Counseling
___ Weight Loss
___ Patient Education

What is your PRIMARY Complaint? ____

How long have you been experiencing this primary complaint? ____________________________

How does the primary complaint feel? __ dull/achy __sharp __numb __tingling __burning __cold

How often do you experience this feeling? __ constantly __ daily __ weekly __ monthly __ yearly

Using the scale below, rate how your complaint affects your life (Circle only one)

1. No Pain
2. Slight Discomfort
3. Pain that does not affect my daily activity
4. Pain that affects my daily activities
5. Pain the prevents performing my daily activities
6. Pain that limits my work schedule
7. Pain that prevents working at all
8. Pain that prevents working and all personal activity
9. Pain that keeps me bed ridden
10. Pain that causes thoughts of suicide

If you have missed work because of your primary complaint, what was your last day of work? _________

What do you believe is causing your primary complaint? ____
____

I understand and agree to the following:

1. A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
2. It is my responsibility to complete the clinic's forms accurately
3. It is my responsibility to notify the doctor if any of my information has changed or requires updating
4. Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

Signature of Parent or Guardian: ____

Date: ____