

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)

- | | |
|--|---|
| <input type="checkbox"/> Injury Prevention | <input type="checkbox"/> Treatment for Pain |
| <input type="checkbox"/> Spinal/Body Alignment | <input type="checkbox"/> Range of motion, mobility or flexibility Therapy |
| <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Nutritional/Supplement Counseling |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> 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: _____