## CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATTENT INFO	MOFIAMS		DAI	· Mil	
Name	SS#				
Name	Annalysis for any file and the design of the state of the	( )		ra mara d 1	
Address	pay,417-1-1				
Age Gender: M F	Birth Date	Marital: M	s b w	How Many Children?	
Occupation					
Address					
Are you a student? Y. N Par					
Name of Husband or Wife					
	Phone				
Name of Nearest Relative	Phone				
Emergecy Contact	` Phone				
Referred by			,	•	
Is the condition due to injury or sickness	ess arising out of employme	at?	Auto or Oth	ner Accident?	
Days lost from work?	Date symptoms appear	ed or accident	happened?	,	
Have you ever had the same or similar	r condition? Yes No	If ye	s, when and d	escribe	
				7	
Name of family physician		CANADA AND AND AND AND AND AND AND AND AN		May we contact? Yes No	
Date of last physical exam	What operations or serie	rus illnesses ha	ave you had a	ad when?	
To a second seco					
Have you ever suffered from: (check a				,	
1. Dizziness	6. Arthritis	est mortus es a la mai de escapadario de mai de mai de descapadario de mai de m	11. Digestive	Disorders	
			12. Nervousness		
3. Heart Trouble	8. Numbness		13. Sinus Trouble		
4. Diabetes	9. Asibma		14. Anomia		
5. Hernia	10. Neuritis	oblickkyljonovini) iminiskustuskylonininininininininininini	15. Rheumati	c Fever	
•			16.Cancer		
Purpose of this appointment	d manufunkke/(malanga). Amay y gybonnesis kaytoy kahal kekayyong alijik dimuyong (pabidik byl gifu mitara) kakayayay	n ( and shipped and common angula bloom melifolds and produces a beginning supports.			
Other doctors seem for this condition _	.  THE Blind SP WANGER FOR BUILDING SPINLS WANGE SHE FOR FOR FOR SHE SHE FOR SHE	The field of Thing persons and page army to the brook which the agency or you would be seen			
Has a physician treated you for any he	alth condition in the last yea	r? Y N D	escribe		
	ing a prompt that is the property and the little of the little of the contract of the second buildings of the property or all before the second buildings of the little of the second buildings of the little of the	the first of the f	d Wangares d'a manare al a aparagina y de la falago de la Manada Appropriação de describir de la Manada Appropriação de la falago de la Manada Appropriação de la falago de la		
what medications or drugs are you take	ing?				
I understand and agree that health and	hirkki unkananni koʻz koʻyveni unoshi i koʻs in hervili aarabi vilking koʻs in tili in tili koʻs in hervili a	INDEALOG BOUGHT UD WAS PERBASING FOR PRESENT	The warmer was an in the state of the state		
I understand and agree that health and not between my insurance company ar complete any usual and customary rep (If mine is a regular health insurance ca am ultimately responsible for payment determined by my treating doctor, any	nd this office. I authorize thi orts and forms at no charge t ase, I agree to pay a percenta t in full at this office. I also	s chiropractic to assist in coll ge of services anderstand tha	climic to relea ecting from n as they are rea t if I suspend	se any medical information and to ny insurance company. ndered. However, I understand that or terminate my schedule of care as	
HEALTH INSURANCE YES 🔲 1	NO COMPANY	ANY POLITICA INVESTIGATION OF LINEARING LIFE COME & APPLICATION OF THE PROPERTY OF THE PROPERT	s		
Insured's Name(PRINT)				Date of Birth	
DATEDITES CICNIATITATION (or quardi	and			Date	

## FINANCIAL POLICY

For the convenience of our patients, the following are stated as a guide to financial arrangements. Please ask for a full explanation of any charges that you do not understand.

	OF PAYMENT Please check one of the following.
Stantines (una que especia des Arrigades) es en cua (que que de casaria se bum	A. Cash. Payment is expected in full as treatment is performed.
, tempopularios propriedos de la constitución de la	B. Health Insurance. Your co-pay is to be paid in full as services are performed. If you have chiropractic coverage, we will cooperate in every reasonable manner. However, you must understand that your bill is your own personal responsibility. If your deductible has not been met, services are to be paid in full at the time of service. Certain plans have a maximum visit limit per year, once that limit is met, you will be switched over to a cash patient and services will need to be paid in full at the time of visit.
Present Carrier and Carrier	C. Medicare. We are a participating provider, meaning we will bill Medicare first and then bill any remaining co-pay to a secondary insurance if you have one. Medicare insurance only covers the spinal manipulation. They do not cover any x-rays, examinations or therapy (such as electrical muscle stimulation or ultrasound therapy). Most of the time when Medicare denies payment for a service the secondary insurance will deny payment also.
	D. Auto Accident/Personal Injury. Please present your personal auto insurance information to the receptionist. No 3rd party insurance will be accepted after you leave our office. You need to make a claim at your insurance agency and then inform us of the claim #, address and phone number. We will bill your insurance company weekly and will send you a statement at the end of care. Please remember you are responsible for your bill. All fees are due at the time of service.
enterprise del de Arapane dell'enterprise dell	— E. Worker's Compensation pays in full for chiropractic care as long as your company authorizes treatment in our office. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.
	Service Charge If I do not pay the entire new balance within 30 days of the monthly billing date, a service charge will be added to the account for the current billing period. The service charge will be a periodic rate of 1.5% per month, (or a minimum charge of \$5.00 for a balance under \$1.00.), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of thus account or future outstanding accounts.
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Patient	s Signature (or guardian) Date