CHIROPRACTIC CASE HISTORY

CONFIDENTIAL PATIENT INFORMATION DATE _____

Name _____ SS# ☐☐☐ ☐☐ ☐☐☐☐

Home Phone ( )____-_____ Cell Phone ( )____-_____ E-mail

Address _____ City _____ State _____ Zip _____

Age _____ Gender: M F Birth Date _____ Marital: M S D W How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Are you a student? Y N Part – Time / Full – Time (circle one) School _____

Name of Husband or Wife _____ Occupation _____

Employer _____ Phone _____

Name of Nearest Relative _____ Phone _____

Emergecy Contact _____ Phone _____

Referred by _____

Is the condition due to injury or sickness arising out of employment? _____ Auto or Other Accident? _____

Days lost from work? _____ Date symptoms appeared or accident happened? _____

Have you ever had the same or similar condition? Yes _____ No _____ If yes, when and describe _____

_____

Name of family physician _____ May we contact? Yes No

Date of last physical exam _____ What operations or serious illnesses have you had and when? _____

_____

Have you ever suffered from: (check all that apply)

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Hernia _____
6. Arthritis _____
7. Headaches _____
8. Numbness _____
9. Asthma _____
10. Neuritis _____
11. Digestive Disorders _____
12. Nervousness _____
13. Sinus Trouble _____
14. Anemia _____
15. Rheumatic Fever _____
16. Cancer _____

Purpose of this appointment _____

Other doctors seen for this condition _____

Has a physician treated you for any health condition in the last year? Y N Describe _____

_____

What medications or drugs are you taking? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.
If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE YES ☐ NO ☐ COMPANY _____

Insured's Name(PRINT) _____ Date of Birth _____

PATIENT'S SIGNATURE (or guardian) _____ 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.

METHODS OF PAYMENT Please check one of the following.

_____ A. Cash. Payment is expected in full as treatment is performed.

_____ 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.

_____ 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.

_____ 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.

_____ _____

Patient's Signature (or guardian) Date