CHIROPRACTIC COMPLETE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Who is your cell phone carrier_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

Marital Status_____ How did you hear about our office_____

List any **Allergies**: **ARE YOU ALLERGIC TO ANY MEDICATION????**

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

List Type of **Medications** you are taking: **Please be brand specific**

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure

□ Other: _____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____

Have you had any auto or other accidents? □ No □Yes
Describe: _____

Date of last physical examination: _____

Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Have you ever had chiropractic care? No yes

When? _____Why? _____

Where? _____

Were X-rays taken? No Yes

When was your last adjustment? _____

Main reason for consulting the office:

- □ **Become pain free**
- □ **Explanation of my condition**
- □ **Learn how to care for my condition**
- □ **Reduce symptoms**
- □ **Resume normal activity level**

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Please fill out this form if you have more than one complaint

What is your SECOND complaint? _____Date problem began?

_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

CHIROPRACTIC Complete

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www.chiropractic-complete.cor

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we supply you with a copy of our privacy policies and procedures. I acknowledge that Chiropractic Complete has offered to supply me with a copy of the Notice of Privacy Practices for Protected Health Information.

_____ _____

Patient (or Personal representative) Signature **Date**

Health Care Information Authorization

We may need to request health related information to better serve you in this office such as reports from other providers or diagnostic facilities (ie. X-ray, MRI reports). By signing below you consent to our requesting such information as pertains your case.

_____ _____

Patient (or Personal Representative) signature **Date**

Office Communications

Our office may need to contact you with appointment reminders, information about treatment or other health related information. You may be contacted by :phone at home or work, mobile phone, e-mail, or postcard.

Messages may be left for you: on answering machine/voicemail at home, work, and on mobile phone.

Or with individuals answering my phone at home, or work.

(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone having access to the reminder or information and may no longer be protected by the federal privacy rules. You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

_____ _____

Patient (or Personal representative) Signature **Date**

Authorization to Release and Pay Benefits Directly

I hereby authorize and direct my insurance carrier to pay all benefits, which may be due me according to my policy, directly to Chiropractic Complete to be applied towards my account. I am also aware that I will be responsible for paying any balance on my account, including co-pays, co-insurance, deductibles, and for any non-covered services. I also authorize Chiropractic Complete to furnish information to my insurance company regarding my care and treatment in a manner consistent with the privacy policies of this office in obtaining payment for services provided.

_____ _____

Patient (or Personal representative) Signature **Date**

FINANCIAL POLICY

Thank you for choosing Chiropractic Complete. The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment. Full payment of your bill is considered a part of your treatment.

Method of payment: WE ACCEPT CASH, CHECK, and CREDIT CARDS. Payment plans may be arranged on an individual basis with our Billing Specialist and/or Doctor in our office.

Regarding your insurance: As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after processing your claim by your carrier is your responsibility.** Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. Interest, at the annual rate of 18%, may be charged to your account if full payment is not received by the statement due date.

Definitions:

CO-PAYMENT: A fixed dollar amount set by your insurance contract that is required to be paid at the time of an office visit. The amount is usually between $10 and $50.

DEDUCTIBLE: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation and must be paid prior to being seen.

CO-INSURANCE: A percent set by your insurance plan that is deducted from insurance benefits. This percent usually ranges between 10% and 30% and is your obligation to pay.

SELF-PAY/CASH ACCOUNTS: A patient that does not have any valid health insurance. You will be asked to pay $_____ before you will be seen for your first visit and $_____ for subsequent visits. This covers the doctor visit and includes adjustments and necessary therapies.

Regarding insurance plans where we are a participating provider: **All co-pays are due prior to treatment**.

MVA policy: Chiropractic Complete will bill your MVA claim to a third party insurance carrier. You will be asked for your personal insurance information for the purpose that should your motor vehicle insurance benefit for this claim become exhausted, we will bill your personal health insurance. If insurance has not paid this claim within 90 days of the date of service, you will be personally responsible for the amount due.

Regarding personal injury: We require a financial arrangement be established for payment in full at the time of service for personal injury cases. We are not a part to any litigation suits being filed for personal injuries.

Regarding work related injuries: We will file Workers Compensation claims with your employer's WC insurance carrier. If your workers compensation carrier has not paid your account in full within a reasonable amount of time, the balance will be transferred to your account and it will be your responsibility to pay in full by the statement due date.

Overdue and in-collection accounts: Patients with past due accounts will be asked to make payment in full before being seen at Chiropractic Complete. Patient accounts sent to collection will not be allowed to schedule any appointments at Chiropractic Complete.

Collections: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

X_____ _____ _____

SIGNATURE of patient PRINT patients name DATE