PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date: _____

Check the type of care desired: ❑ Temporary Relief ❑ Lasting Correction

Name: _____ **Social Security Number:** _____ -_____-_____

Date of Birth: _____ -_____-_____ **Age:** _____ **Height:** _____ **Weight:** _____

Check Marital Status: ❑ Married ❑ Single ❑ Other **Sex:** ❑ Male ❑ Female

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Home Phone: ( )_____ **Work Phone:** ( )_____ **Cell:** ( )_____

Email Address: _____

Nearest Relative: _____ **Phone:** ( )_____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Are you pregnant? ❑ No ❑ Yes Date of Last Menstrual Cycle: _____

EMPLOYMENT INFORMATION

Occupation: _____ **Employer:** _____

Employer Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( )_____

Spouse's Name: _____ **Employer:** _____

Employer Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( )_____

PAYMENT INFORMATION

How will payment be made? *(please check one of the following)*

❑ Cash ❑ Check ❑ Credit Card ❑ Auto Insurance ❑ Health Insurance ❑ Worker Comp

Insurance Company _____ **Policy #** _____ **Group #** _____

Name Of Primary: _____ **Social Security Number:** _____ -_____-_____

Fees are payable at the time X-rays, examinations/treatments are received unless other arrangements are made in advance. X-rays remain the property of the clinic. All accounts over (30) days delinquent will be subject to a 1.5% monthly periodic interest charge to the unpaid balance. All accounts over (60) days delinquent will be turned over for collection or judgment in small claims court. All collection fees, filing fees, attorney fees and court costs incurred by this office in collecting accounts will be charged to the patient.

**By signing below I acknowledge that I have read and understand the HIPPA regulations regarding the privacy of my records and that I reserve the right to designate release of information to any third party.*

Patient Signature: _____

Guardian/Parent Signature Authorizing Care: _____

Patient Name: _____ **Date:** _____

COMPLAINT(S): List in order of severity

****Please mark areas of pain on figures below**

1) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

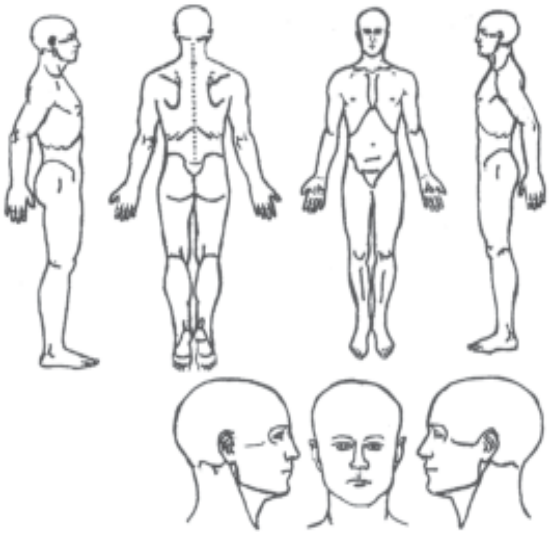
Where to? _____

How bad is the pain? (0 no pain - 10 unbearable)

0——————5——————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



What medication(s) have you taken for this condition?

_____

_____

_____

_____

---

2) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

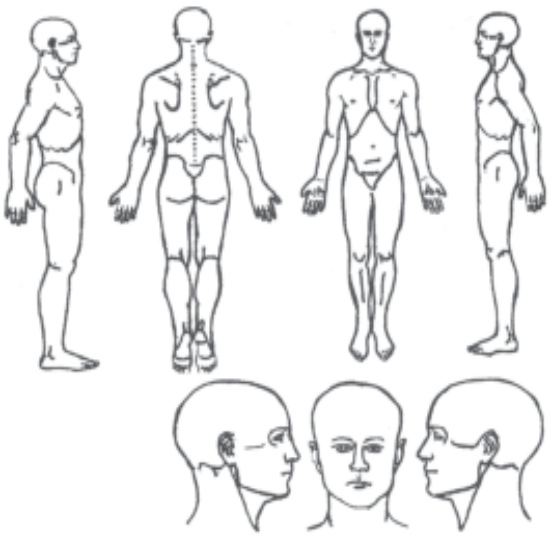
Where to? _____

How bad is the pain? (1 no pain - 10 unbearable)

0——————5——————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



What medication(s) have you taken for this condition?

_____

_____

_____

_____

COMPLAINT(S): List in order of severity

****Please mark areas of pain on figures below**

1) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

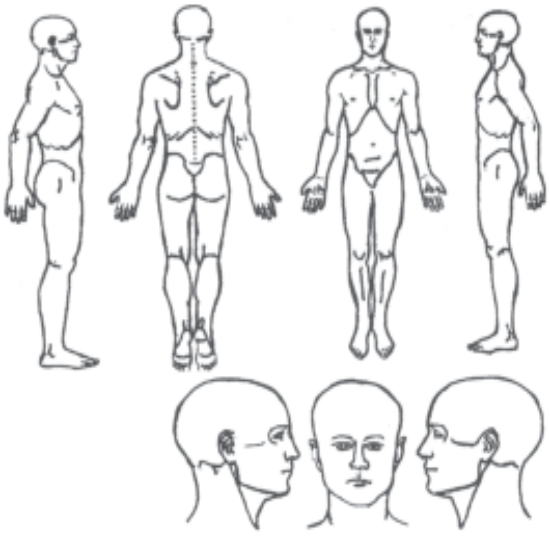
Where to? _____

How bad is the pain? (0 no pain - 10 unbearable)

0——————5——————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



What medication(s) have you taken for this condition?

_____

_____

_____

_____

---

2) _____

Date when symptons first appeared: _____

❑ Constant 100% ❑ Frequent 75%

❑ Intermittent 50% ❑ Occasional 25% ❑ Rare 10%

Describe any related accidents or falls _____

_____

_____

What makes symptoms increase? _____

What gives relief? _____

Type of Pain:

❑ Sharp ❑ Dull ❑ Aching ❑ Burning

❑ Throbbing ❑ Numb ❑ Other _____

Does the pain radiate? ❑ No ❑ Yes

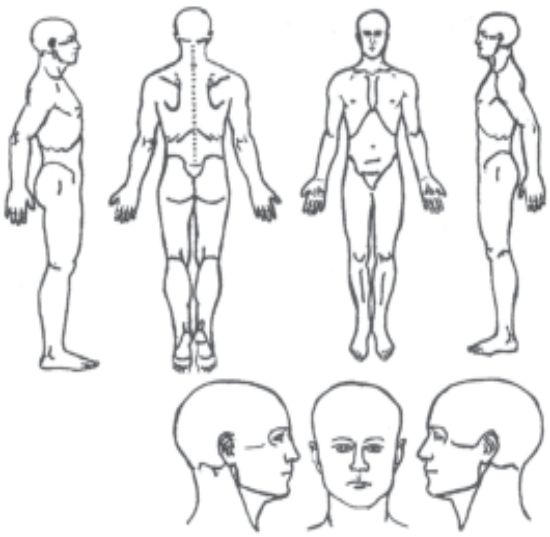
Where to? _____

How bad is the pain? (0 no pain - 10 unbearable)

0——————5——————10

Doctors seen: _____

Does this interfere with: ❑ Work ❑ Sleep ❑ Activities



What medication(s) have you taken for this condition?

_____

_____

_____

_____

Date: _____

PATIENT NAME: _____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **'C'** under his or her column. The designation **'P'** should be used ot indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER Age ____	MOTHER Age ____	SPOUSE Age ____	BROTHER(S) Age ____	Age ____	SISTER(S) Age ____	Age ____	CHILDREN Age ____	Age ____	Age ____
Arthritis										
Asthma										
Back Trouble										
Bursitis										
Cancer										
Carpal Tunnel										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Fibromyalgia										
Headaches										
Heart Trouble										
High BP										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										
Other:										

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **Financial Policy** which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND VISA/MASTERCARD. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

INSURANCE for patients who have insurance we will, at no additional charge, file their claims for payment. If your coverage cannot be verified, services rendered on your initial visit must be paid in full. Partial payment (50%) of the initial visit is allowed if your insurance can be verified but satisfaction of your annual deductible cannot be verified. If we can verify satisfaction of your annual deductible, either from your insurance company or from your **Explanation of Benefits** provided by you, we will collect only your co-payment. Payment of the co-payment may be made either at the time of service, or on a weekly basis, depending on your treatment schedule.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance of your account will be automatically transferred to your credit card or you must be approved on our **Extended Payment Plan.**

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware some services provided may be "non-covered" services and not considered reasonable and necessary under the **Medicare Program** and/or other medical insurance.

On all **DELINQUENT ACCOUNTS** over **30 days old,** there will be a finance charge of **1-1/2% per month** computed and added to the unpaid balance. All unpaid and unresolved balances for which no payments have been received for **60 days** will be automatically turned over for collection. All collection fees will be added to your account and will be your responsibility, should such action prove unavoidable. **DELINQUENT ACCOUNTS** over **60 days** will be charged a **35% fee** and accounts over **90 days** will be charge a **50% fee.**

ALL RETURNED CHECKS WILL BE CHARGED A $15.00 SERVICE CHARGE.

Thank you for understanding our **Financial Policy.** Please let us know if you have any questions or concerns.

I have read this Financial Policy (above). I understand and agree to this Financial Policy:

Signature Patient or Responsible Party: _____

Date: _____

MISSED APPOINTMENT POLICY

Please be aware that as of May 28, 2008 there will be a $40.00 charge for all missed appointments when a call is not received at least one hour prior to the appointment.

Of course, the doctor would much rather see your spine than your money, so please keep your appointment and follow up your treatment plan!

Patients Signature: _____

Date: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Date of Accident: _____ **Time of Accident:** _____

Please explain in detail how your accident happened: _____

_____

_____

_____

What is the estimated cost damage to the vehicle you were in? _____

Were you the:

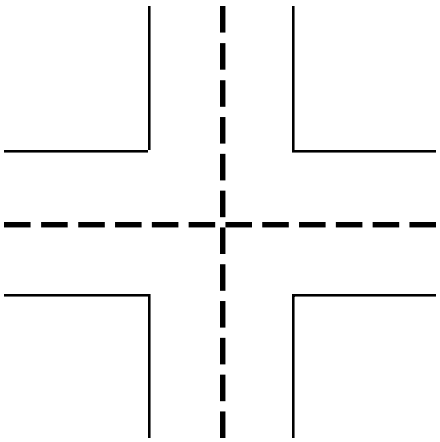
❑ Driver ❑ Passenger ❑ Front ❑ Back ❑ Right ❑ Left

Were you wearing a seatbelt? ❑ No ❑ Yes

If yes, was it a: ❑ Lap Seatbelt ❑ Shoulder Strap Seatbelt

Were you struck from:

❑ Behind ❑ Front ❑ Left Side ❑ Right Side



Was your head looking:

❑ Front ❑ Right ❑ Left

Were your arms on the :

❑ Steering Wheel ❑ Dashboard

Were your legs on the :

❑ Floor ❑ Clutch ❑ Brake

Was the <u>trunk</u> of your body pointed:

❑ Straight Forward ❑ Turned Right ❑ Turned Left

Were you braced for the accident? ❑ No ❑ Yes

Were you thrown about: ❑ Forcefully ❑ Violently

On what part of the automobile did your follow body parts hit?

Head _____ Chest _____

Right/Left Shoulder _____ Right/Left Arm _____

Right/Left Hip _____ Right/Left Leg _____

Right/Left Knee _____ Other _____

Please explain: _____

_____

Did you receive any injury or bruise from the seatbelt? ❑ No ❑ Yes

If YES, then describe: _____

_____

Were you knocked unconscious? ❑ No ❑ Yes **How Long?** _____

Where did you feel pain after the accident? _____

_____

Did you go to a hospital? ❑ No ❑ Yes **Name of Hospital:** _____

What parts of your body were X-rayed at the hospital? _____

How long did you stay at the hospital? _____

AUTOMOBILE ACCIDENT FORM

Patient Name: _____ **Date of Accident:** _____

Was this your vehicle? ❑ No ❑ Yes **State the Accident Happened:** _____

If not, who is the owner? _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( ) _____

Year/Make of Vehicle: _____ **License Tag No:** _____

Name of *Your* Insurance Company: _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( ) _____

Claim Number: _____ **Policy Number:** _____

Your Agent's Name: _____

Does your policy include medical coverage? ❑ No ❑ Yes **Has this been reported?** ❑ No ❑ Yes

Year/Make of Vehicle: _____ **License Tag No:** _____

Name of Driver in other vehicle: _____

Phone: ( ) _____

***Other* Driver's Insurance Company:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone:** ( ) _____

Claim Number: _____ **Policy Number:** _____

Their Agent's Name: _____

Have you retained an attorney? ❑ No ❑ Yes

Name: _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Do you have health insurance? ❑ No ❑ Yes

Name of Insured: _____

Name of Patient: _____

Insurance Company _____

Policy Number: _____ **Group Number:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Personal Injury Deferred Payment Policy.

When seeking care in our office for injuries where a third party is responsible for payment, and there are no other payment options (i.e. medpay, private insurance), we offer a deferred payment option. This option is offered on a case by case basis. If Med. Pay is received by any other party and not promptly forwarded to our office the deferred payment option will be canceled.

In cases where an attorney has been retained, the deferment is continued provided the attorney pursues the case actively and allows our office to verify status each month. If at anytime our office feels the attorney is not addressing the case in a timely manner or the attorney refuses to verify the status we may decide, after consultation with the patient, to cancel the deferred status.

In cases where the patient is seeking to settle the case by him/herself, we allow deferment for 45 days from the date the records are sent to the third party. If at the end of those 45 days the case has not been settled OR attorney representation retained, payment will be due in accordance with the standard financial policy.

I have read the above deferment policy and agree with all the terms and conditions.

Sign X_____

Print _____

Date _____