

## 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**

1) \_\_\_\_\_

Date when symptoms 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

2) \_\_\_\_\_

Date when symptoms first appeared: \_\_\_\_\_

- Constant 100%
- Frequent 75%
- Intermittent 50%
- Occasional 25%
- Rare 10%

Describe any related accidents or falls \_\_\_\_\_

What makes symptoms increase? \_\_\_\_\_

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**Type of Pain:**

- Sharp
- Dull
- Aching
- Burning
- Throbbing
- Numb
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Does the pain radiate?  No  Yes

Where to? \_\_\_\_\_

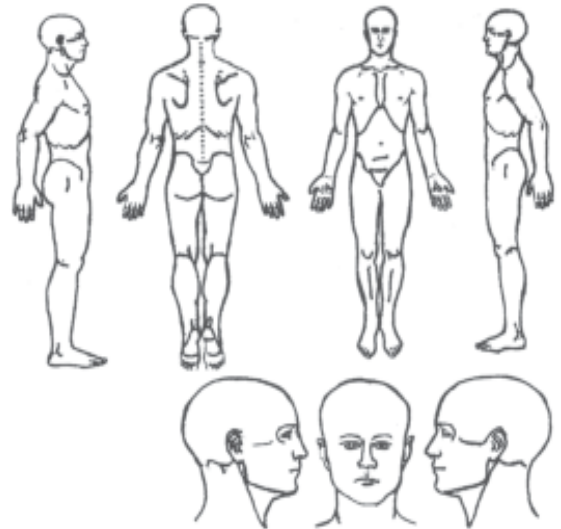
How bad is the pain? ( 1 no pain - 10 unbearable)

0 ————— 5 ————— 10

Doctors seen: \_\_\_\_\_

Does this interfere with:  Work  Sleep  Activities

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

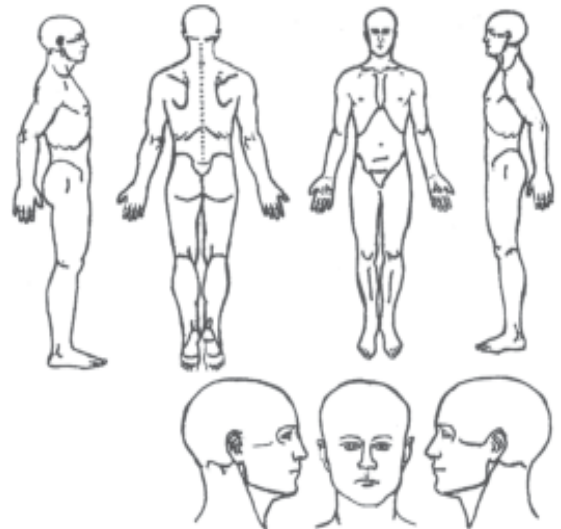


**What medication(s) have you taken for this condition?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Type of Pain:**

- Sharp
- Throbbing
- Dull
- Numb
- Aching
- Other \_\_\_\_\_
- Burning

**Does the pain radiate?**  No  Yes

**Where to?** \_\_\_\_\_

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

0 ————— 5 ————— 10

**Doctors seen:** \_\_\_\_\_

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**Where to?** \_\_\_\_\_

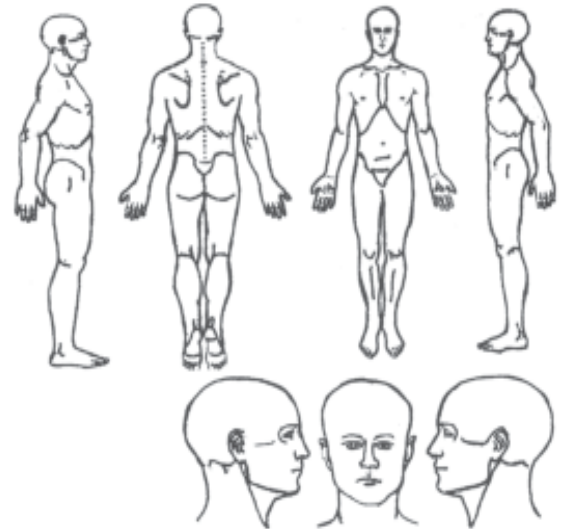
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**Doctors seen:** \_\_\_\_\_

**Does this interfere with:**  Work  Sleep  Activities

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



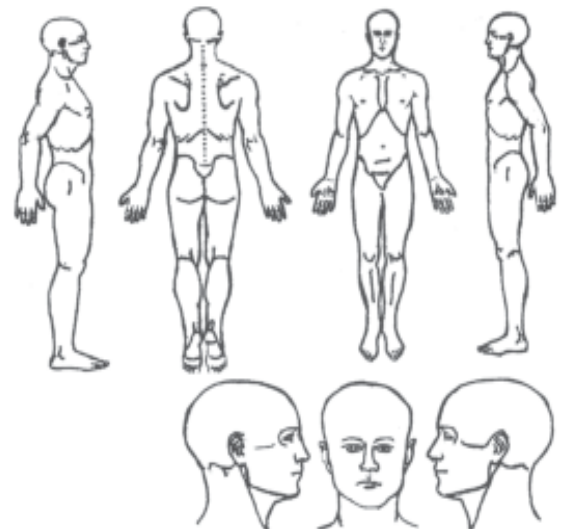
**What medication(s) have you taken for this condition?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## 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.

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**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.**

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**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 trunk 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 \_\_\_\_\_