



Patient Information



Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt No: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Social Security No.: _____

Alternate Phone (cell / pager): _____ e-mail: _____

Date of Birth: ____/____/____ Driver's License (State and Number): _____

Employer / Name of School: _____ Full Time Part Time

Sex: Male Female Marital Status: Single Married Divorced Widowed

If Applicable:

Spouse's Last Name: _____ First Name: _____ Middle Initial: _____

Spouse's Work Phone: _____ Spouse's Social Security No.: _____

Responsible Party Information (if different from above)

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: Self Spouse Parent Other _____

Responsible Party's Home Phone: _____ Work Phone: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Insurance Information (Please present insurance card to receptionist)

PRIMARY Insurance Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Insured: Self Spouse Parent Other _____

Insurance ID No.: _____ Group No.: _____

SECONDARY Insurance Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Relationship to Insured: Self Spouse Parent Other _____

Insurance ID No.: _____ Group No.: _____

Medicare Number: _____ Medicaid Number: _____

Patient Referral Information

Referred By: _____ Other physicians who care for you: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Alternate Phone No.: _____

I authorize the attending physician to release my medical information for consultation, referral, or insurance processing purposes. I authorize my insurance company(ies) to pay benefits directly to the physician.

Patient Signature: _____ Date: _____

Payment is due at the time services are rendered. As a courtesy we will file your insurance so that you may be reimbursed.

Patient Name: _____

Symptoms:

If you have ever had a listed symptom in the **past**, please check that symptom in the **Past** column. If you are **presently** troubled by a particular symptom, check that symptom in the **Present** column. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Irregular Bowel Movements |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (Chronic Lung Disease) |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |

- | Past | Present | Condition |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (ear noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

If a **family member** has had any of the following, please mark the appropriate box.

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |

Do you have a permanent disability rating? YES NO

Location: _____

Date rating received ____/____/____

Rating percentage _____%

Present Weight _____ pounds Height _____ feet _____ inches

FOR WOMEN ONLY

Date of last menstrual cycle: _____

Are you pregnant? YES NO If yes, due date? _____

Are you nursing? YES NO

Are you taking birth control pills? YES NO

Do you have breast implants? YES NO

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages.

Patient's Signature: _____ **Date:** _____

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to ask at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, our staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: _____

We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy that we require you to read, agree to and sign prior to any treatment.

We accept Cash, Checks, Money Orders and Visa/Mastercard.

Medicare

As participating providers, we accept assignment of benefits and will file all claims for you. You are responsible for full payment of any deductible and/or co-pay and non-covered services at the time those services are rendered.

HMO/PPO and Other Managed Care

We will file all insurance claims for you. It is your responsibility to ensure your insurance company has been informed of your PCP designation and all appointments are scheduled with your PCP, except in the event of an emergency. It is also your responsibility to present your insurance card prior to services being rendered. All co-pays and deductible are due at the time services are rendered.

Other Insurance

As a courtesy, we will file your insurance claims; however, you must provide all insurance information and a completed claim form (if required) at the time of service. Please understand that your insurance policy is a contract between you and your company. We are not a party to that contract; therefore, the balance is your responsibility whether your insurance company pays or not. Payment is due in full at the time of service. If you do not wish for us to file your claims with your insurance, please notify the front desk so your account will be set up as a self pay.

U.C.R. (Usual and Customary Rate)

Our practice is committed to providing the best possible treatment and we charge what is usual and customary for our area. You are responsible for paying the bill regardless of the insurance company's determination of usual and customary rates. EXCEPTIONS: MEDICARE, MANAGED CARE HMO and PPO.

Self Pay

Payment is due in full at the time of service.

Delinquent Accounts

Accounts that are not paid in full or satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, or to an attorney for further action.

Change in Insurance, Patient Information

It is your responsibility to notify our office in the event of any change in your insurance, address, phone numbers, etc.

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

I have read, understand, and agree to the above Financial Policy.

Patient or Responsible Party

Date

Witness

Date

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize Dr. Mary Collings and whomever she may designate as her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that she deems necessary in my case; and I further authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the office or to the patient or a family member or employer of the patient for all or part of the office's charge, including and not limited to, hospital or medical service company, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Patient Signature: _____ Date: _____