WELCOME

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." —Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____ Date_____ SS#_____-_____-_____
First Middle Initial Last

Address_____ City_____ State_____ Zip_____

Sex: Female Male Birthdate_____ E-mail_____

Home Phone (_____)_____ Cell Phone(_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for_____ years

Patient Employer/School_____ Occupation_____

Employer/School Address_____ City_____ State_____ Zip_____

Spouse or parent's name_____ Employer_____ Work Phone (_____)_____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone (_____)_____

Responsible Party

Name of person responsible for this account_____

Relationship to patient_____ Phone (_____)_____

Address_____ City_____ State_____ Zip_____

Name of employer_____ Work Phone (_____)_____

Insurance Information

Name of insured_____ Relationship to patient_____

Birthdate_____ Social Security #_____ Date employed_____

Name of employer_____ Work Phone (_____)_____

Address_____ City_____ State_____ Zip_____

Insurance Co._____ Phone (_____)_____ Group #_____ Employer #_____

Insurance Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Symptoms

Reason for visit_____ When did you first notice the symptoms_____

Is this condition getting progressively worse?_____

Where specifically is the problem(s) located?_____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity pf your pain. (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other_____
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	_____

Dates of last exams _____

(Women) Are you pregnant? ☐Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐No

List any types of surgeries which you have had and the dates which they occurred:

_____

Please list all medicines you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take?_____

What kind of nutritional supplements do you take(if any)?_____

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis?_____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health.

I certify that I, or my dependent(s) have insured coverage with_____

And assign directly to Dr. Strathman all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Patient Financial Information

Personal Injury or Automobile Accidents

Please present your insurance forms as soon as possible. If an attorney is handling your case, please notify our insurance department right away. As a courtesy, the office will file with your auto medical pay, liability and health insurance. If you do not have auto medical pay, the front desk will help you set up payments. Once your case is closed, and you have been released from corrective care; payment is expected within 60 days. **If you suspend or terminate care against medical advice, any fees for service are due immediately**.

Patients Without Insurance

1. We offer a "time of service" discount of 15%. To qualify for this discount payment **must** be made the day the service is provided, or you may pre-pay for the week.
2. For your convenience, payment may be arranged at the last visit of each week. However, payments made at the end of the week do not qualify for the 15% discount.
3. We are happy to accept cash, check, Master Card, Visa or Discover

Return Checks/Collection Agency

There will be a $25.00 fee on all returned checks. If we have to involve a collection agency there will be a fee of 35% of the balance added to the total balance. If legal action has to be taken a fee of 45% of the full balance will be added.

Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover. For Chiropractors this includes **only** manual manipulations of the spine. Medicare pays 80% of the allowable fee once the deductible has been met and the patient will be required to pay the remaining 20%. The patient is also responsible of payment in full of all non-covered services. Subsequent services will be payable at the end of each week or from a monthly statement. Our office will complete the necessary forms and file them with the Medicare provider at no charge.

Group or Individual Insurance

I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between this chiropractic center and my insurance company. I request that the chiropractic center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at the chiropractic center that fees will be due and payable immediately. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

Missed Appointment Fee:

This office will charge a fee of $25.00 for any appointment not kept. Appointments that are rescheduled within 24 hours of appointment time will not be charged a fee.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

Patient Health Information Consent Form

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 the 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 read the HIPAA Notice that is available to you 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 effect 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, all staff has been trained in the area of patient record privacy and a privacy official has been designed 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 readily 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 health care operations, the chiropractic physician 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.

_____

Name of Patient Date

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Strathman and whomever he may designate as his assistants to administer treatment as he so deems necessary to my (circle one) son/daughter,_____. Dated at Kearney Family Chiropractic Center this _____ day of_____, 20_____.

Signed:_____

Witnessed:_____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Strathman and whomever he may designate as his assistants to administer treatment as he so deems necessary to my (circle one) son/daughter,_____. Dated at Kearney Family Chiropractic Center this _____ day of_____, 20_____.

Signed:_____

Witnessed:_____