NEW PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____ DOB:_____
Address:_____
City:_____ State:_____ Zip:_____
Home #:_____Work #:_____
Cell#: _____E-Mail- _____
SS#:_____ Marital Status (S-M-Sep-D-W) Sex: (Male/Female) Age: ____
Employer:_____ Work Title:_____
Name & Phone # of Relative or Neighbor_____
Name of Spouse_____ Spouse Employer_____
Spouse DOB_____ Spouse Work #_____ Spouse SS#_____
Who is responsible for this account (Patient/Insurance)?_____
Is this case covered by insurance (Blue Cross, Auto Accident Ins., Medicare, etc.) Yes/No
Insurance Carrier:_____ Phone #:_____
Policy #_____Group #_____ Subscriber_____
Major Complaint (Back Pain, Neck Pain, etc.) _____
_____
Whom may we thank for referring you to our office?_____
(Doctor, Patient, Friend, Relative, Newspaper, Yellow Pages, Internet, Other?)
Is this a result of: Auto Accident ___ Work Injury ___ Other _____
Date of Injury: _____ Do you have an Attorney (Name)? _____
Describe Accident: _____
_____

Women Only:

Are you pregnant? Yes/No Date of last menstrual period: _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

PAYMENT POLICY

I understand that this office will file my insurance claim for me upon request and that any amount paid directly to this office by my insurance company will be credited to my account. However, I clearly understand and agree that I am personally responsible for paying fee's for service (regardless of my insurance coverage) and at any time it can be request that I pay all or part of the balance of my account.

I have read and understand the foregoing.

Patient's Signature _____Date_____

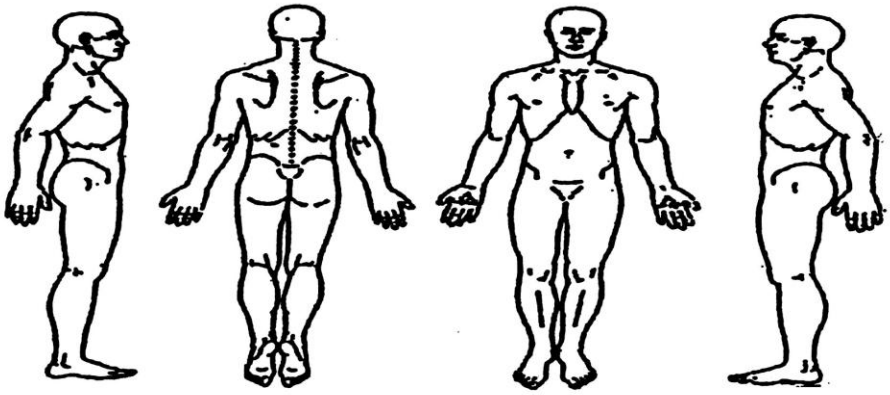
Witness Signature_____ Date _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) Problem #1 _____
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) Problem #2 _____
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) Problem #3 _____
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*) Problem #4 _____

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Hughes Chiropractic . I understand that my insurance is an arrangement between myself and my insurance company, NOT between Hughes Chiropractic and my insurance company. I request that Hughes Chiropractic 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 doctors at Hughes Chiropractic that fees will be due and payable immediately.

_____

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

_____

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name:_____

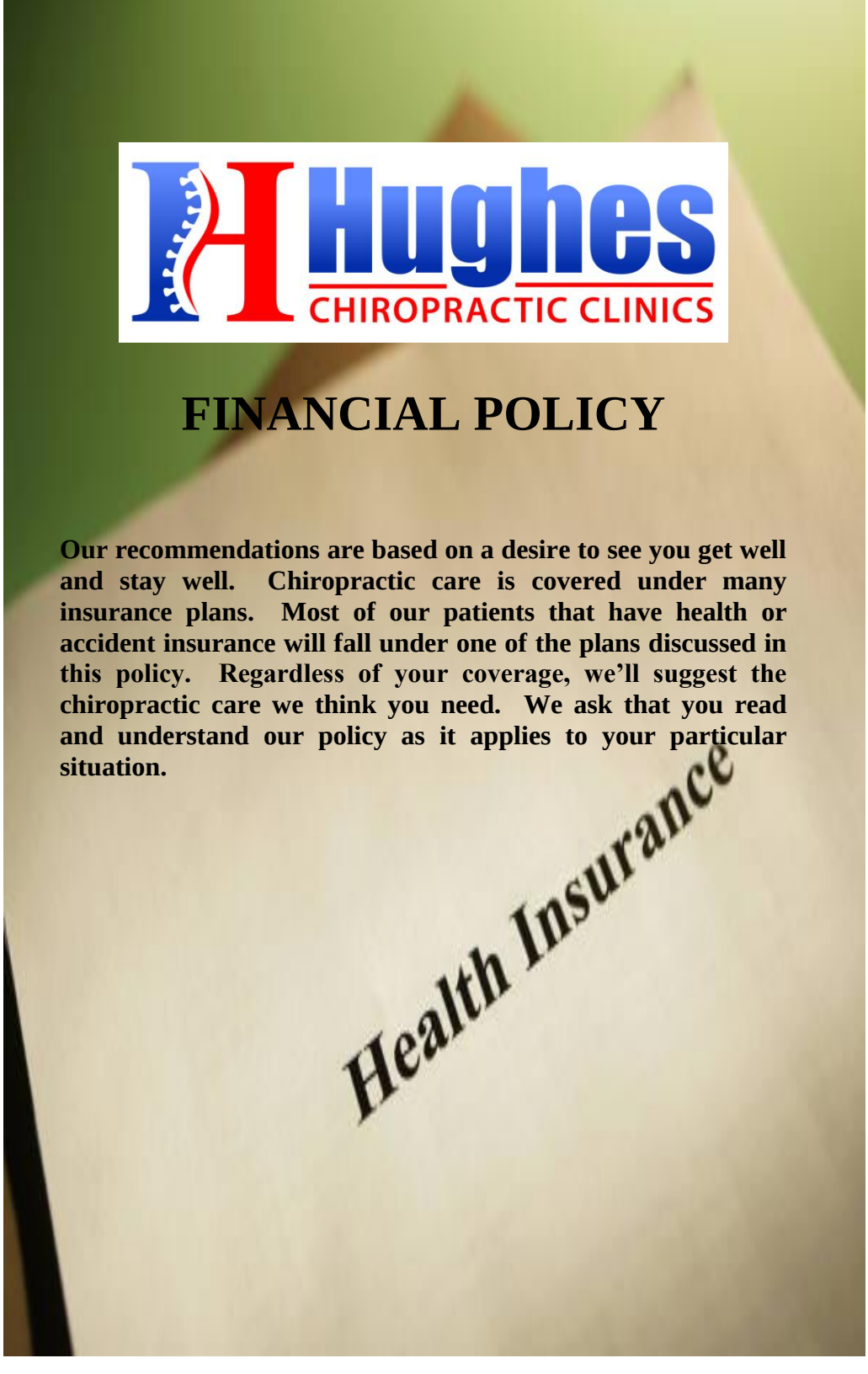
1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $_____co-pay of each visit due by you.

Hughes CHIROPRACTIC CLINICS

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.



PATIENTS WITHOUT INSURANCE OR UNDERINSURED

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week, if you sign a credit guarantee form. We offer a **20% Time of Service Discount of billable charges if balances are paid in full the week they are rendered**. **We also are participating providers in certain health discount networks.** We are happy to accept your check, cash or credit card. We also have "Care Financing Plans" with **0% interest for up 6 months**. Ask to find out how to qualify.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. 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. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. If we are not a participating provider of your insurance, you may pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees as stated above. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, or if the insurance company does not approve care, you will be responsible for payment.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS OPTIONS

1. Pay in full for your care with cash, check or credit card as your charges are incurred, and we will submit reports whenever necessary
2. If you have a Med Pay policy on your personal auto insurance, we will bill this portion of your auto insurance ***if paid directly to us by the insurance***.
3. With a signed Assignment & Lien form, we will send bills & reports to your attorney.

Due to South Carolina lien laws, our office does not deal directly with insurance carriers to negotiate settlement of you claim. We also do not accept personal injury patients that want to negotiate settlement with the insurance company directly without legal representation. If you do not have Med Pay on your personal auto insurance policy, and choose not to pay for your charges as they are incurred, our office will be happy to assist you in obtaining legal representation to assist in negotiating settlement of your auto accident claim.

Our office will wait up to 6 months after release from care if you have an attorney and have a credit guarantee on file. Once the claim is settled, or if you suspend/terminate care, or drop legal representation, any fees are due immediately.

MEDICARE

We do not accept assignment from Medicare. The check is sent directly to you for payment of the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

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

MANAGED CARE PLANS

We are preferred providers for various health insurance carriers
□ You are required to pay a $_____co-pay at the time of service.
□ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.
□ Benefits are available for up to _____visits per year. A $_____co-pay is due at the time of service.
□ A _____% co-insurance is required on each visit. A credit guarantee is required to cover this amount and will be billed after an EOB is received with amount due after contracted insurance write-offs. A receipt along with a copy of the EOB will be mailed to you.
□ A special deductible of $_____ is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We can assist you in utilizing these in our office.