WELCOME TO ANDREWS FAMILY CHIROPRACTIC

Please fill out this form as completely as possible.

All the information requested below, is necessary for us to serve you the best way possible.

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____ Age:_____

Birth Date:_____ Occupation:_____ Years in this occupation: _____

Employer:_____ Marital: M S W D

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

Whom may we thank for referring you to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor_____

Andrews Family Chiropractic Clinic

Health Information and Health History

Primary Complaint_____

Secondary Complaint_____

When did your problem begin?_____

How did your problem begin?_____

Is this problem interfering with your: (cirlcle any that apply)

Activities of daily living Work Social Activities Hobbies Sleep

Rate your pain (circle one) 0 being no pain or 10 being the worst pain

0 1 2 3 4 5 6 7 8 9 10

In your health problem worse: (circle one) Morning Day Evening Night

Does your problem occur: (circle one)

Occasionally Intermittently Constantly Frequently

Is your problem getting: (circle one) Better Worse Staying the Same

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

What aggravates your health problem: (circle all that apply)

Coughing Sneezing Walking

Reaching Lifting Bending

Sitting Lying down Standing

Neck movement Straining at stool

Others_____

What relieves your health problem: (circle all that apply)

Nothing Resting Heat

Sitting Standing Ice

Others_____

Have you had recent treatment for this condition? ☐ Yes ☐ No

Who did you see? _____Treatment_____

Have you had any changes in bowel or bladder habits since your problem began? ☐ Yes ☐ No

Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you been hospitalized in the past five years? ☐ Yes ☐ No

Date and Reason: _____

PATIENT NAME _____

DATE _____ Doctor_____

Have you had any serious accidents in the past five years? ☐Yes ☐ No
Date and Reason: _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

Have you seen a doctor of chiropractic: ☐ Yes ☐ No

List your medications;_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any Congenital Condition? ☐ Yes ☐ No If YES, Describe _____

Have you had any accidents related to the any of the following? (circle all that apply)

Automobile Motorcycle Bicycle Playground Abuse

If yes, please explain how and dates: _____

_____

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips? ☐ Yes ☐ No
If yes, please explain how and dates: _____

_____

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, please explain how and dates: _____

_____

In the last 6 months have you suffered from: Circle all that apply or circle normal

General:	Fatigue	Weakness	Weight Change	Loss of Sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision Trouble	Dryness	Cataract/Glaucoma	Redness	Normal
Nose:	Pain	Bleeding	Sinus Trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing Palpitations	Sneezing Hypertension	Wheezing	Chest Pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite Change	Heartburn	Normal
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

PATIENT NAME _____

DATE _____ Doctor_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Other Mental Stresses

_____ Family Pressures

_____ Financial Pressures

_____ Other (specify)_____

Please indicate how frequently and quantity consumed for the following:

Alcohol Use: Frequency (please circle one) None Occasional Daily Weekly
Quantity: _____ Type: _____

Drug Use: ☐ Yes ☐ No Type: _____ Last time used: _____

Tobacco Use: _____packs/day Please circle: Cigarettes Cigar Chewing Tobacco

Caffeine: _____cups per day

Have you ever had any of the following: (circle all that apply)

Arthritis	Heart Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever
Asthma	Bone Fracture	Tuberculosis
Epilepsy	High Blood Pressure	Serious Injury
Allergies	Low Blood Pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble
Scoliosis	Spinal Disease	Polio
Cancer	Thyroid Trouble	HIV
Ulcer	Sexually Transmitted Disease	AIDS

FAMILY HISTORY

Has anyone in your family had any of the following: (if yes, list relationship to the patient)
Cancer: _____ Diabetes: _____
Heart Trouble: _____ High Blood Pressure: _____

Do any family members suffer from the following: (please circle and list the relationship to you)

Neck Problems: _____
Back Problems: _____
Headaches: _____
Arthritis: _____
Disc Problems: _____
Pinched Nerves: _____
Bad Posture: _____
Scoliosis: _____
Osteoporosis: _____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

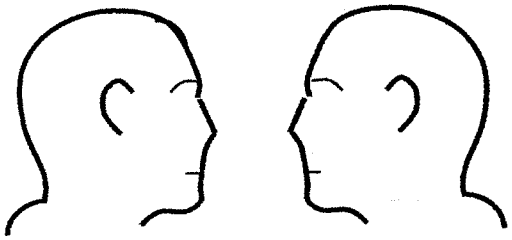
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

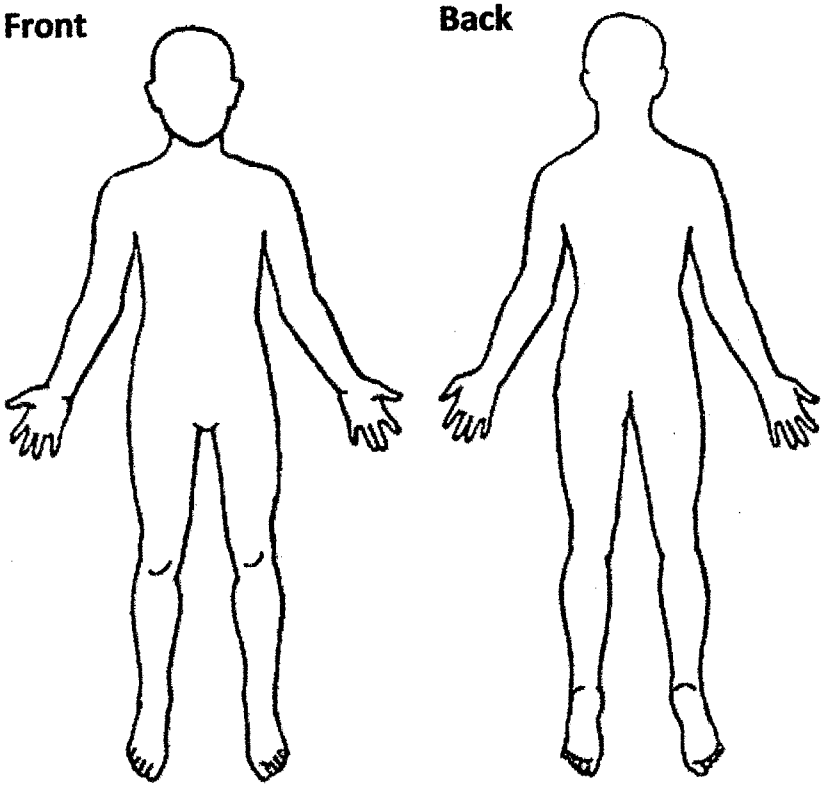
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

PATIENT NAME _____

DATE _____ Doctor_____

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period: _____
If pregnant, what is the due date? _____ Name of OBGYN or midwife _____
Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐Other

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

For internal purposes only:

Doctor's Signature: _____

Date reviewed: _____

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 financial and payment policy of Andrews Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Andrews Family Chiropractic and my insurance company. I request that Andrews Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits.

_____

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

_____

Witness

Andrews Family Chiropractic

FINANCIAL and PAYMENT 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

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 are happy to accept your check, Master Card or Visa.

ALL PATIENTS UTILIZING THEIR INSURANCE BENEFITS:

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, co-insurances, or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. 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, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

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 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. Secondary insurance may or may not pay for these 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 the following companies: United Health Care, Medica, Great West, Blue Plus, Blue Cross Blue Shield (Federal, Minnesota, and out of state plans), Select Care, most Aetna plans, Ucare, and Healthpartners.

MEDICAID

If you have Medicaid, Blue Plus, or Ucare we are providers for those plans. These plans typically cover one examination per year, x-rays and spinal adjustments. All other services are considered non-covered and are considered your financial responsibility.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)