Patient Information

Date_____

Name _____Social Security # _____Home Phone _____

Address _____City _____State_____ Zip _____

E-mail address: _____ Fax # _____ Cell Phone _____

Age _____ Birth Date _____ Race _____Marital: M S W D How many children? _____

Occupation _____Employer _____

Employer's Address _____ Office Phone_____

Spouse _____ Occupation _____Employer _____

Name of Nearest Relative _____Address_____Phone _____

How were you referred to our office? _____

Family Medical Doctor _____ Address: _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

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

_____

Days lost from work _____

Date of last physical examination _____What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates) _____

_____

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

If yes, describe: _____

_____

What medications or drugs are you taking? _____

_____

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

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid

☐ Medicare ☐ Auto Accident ☐ 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

Permission to email: Initials _____

Permission to contact Physician: Initials _____

PATIENT HISTORY
PERSONAL HISTORY

Patient_____ Date_____
Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Others_____
Unusual Childhood Diseases:_____
Adult Illnesses or Conditions: _____
Surgeries/Hospitalizations:_____
Fractures:_____
Medications:_____
Are you allergic to any drugs or medications?_____
Last Physical (date) _____ Findings:_____

Chief Symptoms

_____
_____
_____
_____

Have you ever had the same or similar condition? Yes_____ No_____ If yes, when and describe _____
_____
Have you seen any other doctors for this condition?_____
Is the condition due to injury or sickness arising out of employment? _____
Is the condition due to injury or sickness arising out of an auto or other accident? _____
Days lost from work?_____ Date symptoms appeared or accident happened _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Women: Are you pregnant?_____			

SOCIAL HISTORY

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

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____Patient's Signature_____

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

Name_____ (Print Patient's Name)

Date_____

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)

I have read and understand the payment policy of DeLorey Chiropractic Clinic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between DeLorey Chiropratic Clinic and my insurance company. I request that DeLorey Chiropractic Clinic 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 DeLorey Chiropractic Clinic 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:_____

Insurance Deductible:_____

Deductible as yet unsatisfied:_____

Co-Insurance Percentage:_____

DeLorey Chiropractic Clinic

FINANCIAL POLICY

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. 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, Visa, or Discover.

GROUP OR INDIVIDUAL INSURANCE

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 is due at the time of service for any non-covered services, deductibles or co-pays.

FLEX PLANS/HEALTH SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes referred to as 'flex plan'. We will be happy to provide you with a statement 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 2 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 2 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 co-insurance as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

MEDICAID

We do not accept assignment from Medicaid.

SECONDARY INSURANCE

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

"TIME OF SERVICE" DISCOUNT

A "time of service" discount in the amount of 10% is available on all spinal and extremity adjustments when no insurance billing is needed. X-rays and exams are not included in the "time of service" discount. For this discount to be in effect, payment must be made on the **same day** that the service is rendered.

CARE CREDIT

We are proud to say we are a Care Credit Provider.
Care Credit offers NO INTEREST payment plans for 3, 6 or 12 months. With Care Credit you can pay for co-payments, deductibles, and treatment not covered by insurance. No annual fees apply. Care Credit is a division of GE Financing, available in all 50 states and can be used for medical, dental and veterinarian needs.

CREDIT GUARANTEE
INSURANCE ASSIGNMENT
PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 60 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 48 hours after your first visit.

On Day 60, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

CREDIT CARD: ❒ DEBIT ❒ VISA ❒ MC ❒ DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE_____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 60 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

_____ _____

SIGNATURE DATE