Welcome to Stangl Chiropractic!

Name: _____ Nickname: _____
First M.I. Last

Birth Date: _____ /_____ /_____ Age: _____ Social Security: _____-_____-_____ Marital Status: ____

Home Address: _____
Street City State Zip Code

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____ Best time/place to be reached: _____

Whom should we thank for referring you? _____

Who is your Medical Physician? _____ May we send a report? _____

Doctor: _____
Physician's Name Address Phone Number

Who is authorized to discuss your account (other than yourself):

1. _____ 2. _____

Emergency Contact and Phone #_____

_____

Primary Insurance

Insurance Co. _____
Insurance Name Claim Address

Policy #: _____ Group #: _____ Referral Needed: _____

Policyholder: _____ Date of Birth: ____ / ____ / ____ Male/Female

Employer: _____
Name of Business Mailing Address Phone Number

Secondary Insurance

Insurance Co. _____
Insurance Name Claim Address

Policy # _____ Group # _____ Referral Needed _____

Policyholder _____ Date of Birth ____ / ____ /____ Male/Female

Employer _____
Name of Business Mailing Address Phone Number

Reason for Visit

Please describe the reason for the visit: _____
_____
_____
Where is the pain located? _____ When did the condition begin? ____ / ____ / ____
Is the pain getting worse? ____ **YES** _____**NO** Have you had similar symptoms in the past? ____ **YES** _____ **NO**
Have you been treated by a Chiropractor before? ____ **YES** _____ **NO** If so, when/where: _____
Have you been treated by a Medical Physician for this condition? _____ **YES** _____**NO**
If so, when/ where: _____
Is the problem a result of an injury due to **work**, **auto accident**, or **fall**? _____**YES** _____**NO**

Medical History

Are you currently taking any medications? _____
Please list any medical conditions you have/ had: _____
List any previous surgeries and dates: _____
Please list anything you are allergic to: _____
List any past serious accidents and dates: _____
Do you smoke? ____ **YES** _____ **NO** How many packs a week? _____ How long? _____
Are you wearing _____ **HEEL LIFTS** _____**SOLE LIFTS** _____ **INNER SOLES** _____ **ARCH SUPPORTS**
What is the age of your mattress? _____ Is it comfortable? _____ Are you taking birth control? ____ **YES** ____**NO**
Are you pregnant? _____**YES** _____ **NO** If so, how long? _____ Are you nursing? _____**YES** _____**NO**

Diseases and Medical Conditions

Y N HEART ATTACK / STROKE	**Y N HEART SURGERY / PACEMAKER**	**Y N HEART MURMUR**
Y N CONGENITAL HEART DEFECT	**Y N MITRAL VALVE PROLAPSE**	**Y N ARTIFICIAL VALVES**
Y N ALCOHOL / DRUB ABUSE	**Y N VENEREAL DISEASE**	**Y N HEPATITIS**
Y N HIV + / AIDS	**Y N SHINGLES**	**Y N CANCER**
Y N FREQUENT NECK PAIN	**Y N EMPHYSEMA / GLAUCOMA**	**Y N ANEMIA**
Y N HIGH/ LOW BLOOD PRESSURE	**Y N PSYCHIATRIC PROBLEMS**	**Y N RHEUMATIC FEVER**
Y N SEVERE/FREQUENT HEADACHES	**Y N KIDNEY PROBLEMS**	**Y N ULCERS/COLITIS**
Y N FAINTING/SEIZURES/EPILEPSY	**Y N SINUS PROBLEMS**	**Y N ASTHMA**
Y N DIABETES/TUBERCULOSIS	**Y N DIFFICULTY BREATHING**	**Y N CHEMOTHERAPY**
Y N LOWER BACK PROBLEMS	**Y N ARTIFICIAL BONES/JOINTS**	**Y N ARTHRITIS**
Y N UNEXPLAINED WEIGHT CHANGES	**Y N UNEXPLAINED FEVERS**	**Y N NIGHT SWEATS**
Y N WEAKNESS/FATIGUE	**Y N LOSS OF APPETITE**	**Y N IMMUNE DEFICIENCIES**
Y N JOINT PAIN	**Y N JOINT SWELLING**	**Y N MUSCLE PAIN**
Y N MUSCLE CRAMPS	**Y N RASHES**	**Y N CHANGES IN SKIN**
Y N CHANGES IN NAILS	**Y N CHANGES IN HAIR**	**Y N EYE PAIN**
Y N DOUBLE VISION	**Y N BLURRED VISION**	**Y N RINGING IN YOUR EARS**
Y N EAR PAIN	**Y N NASAL DISCHARGE**	**Y N NOSE BLEEDS**
Y N SINUS PAIN	**Y N HOARSENESS**	**Y N DIFFICULTY SWALLOWING**
Y N CHEST PAIN	**Y N WHEEZING**	**Y N COUGHING**

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between patient and doctor.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you bill responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis treatment. I also authorize the provider to release any information required to process insurance claims.

_____ _____
Signature Date

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request is we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give authorization, it will no affect the treatment we provide or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature Authorized Provider Representative

_____ _____

Personal Representative's Printed Name Personal Representative's Signature

_____

Description of Personal Representative's Authority to Act for the Patient.

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital, if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are ot required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	

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. To receive our Time of Service discount payment MUST be made at the time of the visit. Payments for future visits may be made in advance. We are happy to accept your check, MasterCard, Visa, Discover or American Express.

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. 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.

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 six months after your care is completed. Once the claims is settled or if you suspend or terminate care, any fees for services are due immediately.

"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.

MEDICARE

We do not accept assignment from Medicare. Payment of visit is anticipated at the time of service. However, as a courtesy we will submit your services to Medicare so that you may seek reimbursement. Medicare only covers Active care adjustments. Maintenance visits, exams, x-rays, rehab, and any other modalities are not covered by Medicare.

SECONDARY INSURANCE

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

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

POLICY CHANGES/NEW INSURANCE CARDS

It is ***essential*** that you notify our office immediately if you have a change in coverage or have received a new insurance card in the mail. These changes generally indicate a change or modification in the way you policy pays for our services. Failure to provide our office with current insurance information can result in non-payment for our services. **If this should occur the patient will be responsible for all services rendered.**

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.

Your plan details (as per **YOUR** insurance company: Insurance Rep:_____)

- Effective Date:_____.
- Copay/Coinsurance:_____.
- Deductible: YES/NO $_____.
- # of visits per year:_____.
- X-Rays: YES/NO_____.
- Modalities: YES/NO visits per yr_____.
- Referral/Pre-Authorization YES/NO after _____ visits

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

_____

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

_____

Witness

TERMS OF ACCEPTANCE

In the course of chiropractic health care, it is essential for the physician and patient to work towards the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

ADJUSTMENTS

An adjustment is the specific application of forces to facilitate the body's collection of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH

A state of optimal physical, mental and social well being, not just the absence of infirmity.

VERTEBRAL SUBLUXATION

A misalignment of one or more of the 24 vertebra in the spinal column (which causes alteration of nerve function and interference to the transmission of mental impulses), which can impair the body's ability to achieve maximum health potential.

If during the course of chiropractic examination we encounter non-chiropractic or unusual findings, which we do not treat; we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

We do not offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our methods include adjusting to correct vertebral subluxations, balancing the nervous system, and prescribing nutrients, herbs, homeopathies, exercise, diet, and lifestyle modification.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

PENNSYLVANIA CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Pennsylvania Chiropractic Association (PCA). This disclosure will be made if we need the PCA's assistance to receive reimbursement for your services or we need the PCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the PCA this information. You are also giving the PCA authorization to re-disclose your information to the party responsible for the payment of your services, the PCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the PCA at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature Authorized Provider Representative

_____ _____

Personal Representative's Printed Name Personal Representative's Signature

_____

Description of personal representative's authority to act for the patient.