

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	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	_____

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__

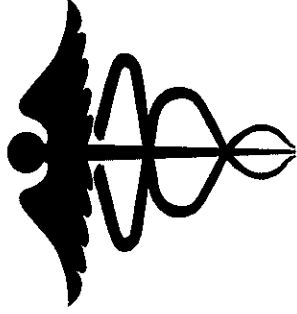
By _____
Patient's Signature

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

By _____
Signature of Parent/Guardian (circle one)

DeLorey Chiropractic Clinic

FINANCIAL POLICY



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 Chiropractic 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: _____

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 accept assignment from Medicaid. Payment is due at the time of service for any co-payments.

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: VISA MC DISCOVER AMERICAN EXPRESS

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

CVV _____

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