

Patient Health History

Today's Date

Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth

Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino Japanese

Korean Vietnamese Native Hawaiian or other Pacific Island

Samoan Guamanian or Chamorro Other _____ I choose not to specify

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Continued ...

NAME: _____

DATE: _____

Verification Question (choose only one question by circling the question, then give the answer to that question)

- Where was I on 9/11?
- City I was married in?
- What is your favorite car?
- What is your mother's maiden name?
- City I went to school in?
- Pet's name?
- City I was born in?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

- What is you smoking status?** Current every day smoker Current somedays smoker Former smoker
- Never been a smoker Smoker, current status unknown Unknown if ever smoked
- Heavy tobacco smoker Light tobacco smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
- No interest* *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here:

	Dosage		Dosage
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Briefly list your main health problem(s): _____

Has any doctor diagnosed you with Hypertension presently? Yes No **If yes, describe:** _____

Has any doctor diagnosed you with Diabetes presently? Yes No **If yes, what kind?** Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

To be performed by clinic staff:

Height: _____ inches **Weight:** _____ pounds **BP:** _____ / _____

Patient Data _____ **DATE** _____

Patient Title(check one): Mr. Mrs. Miss Ms. Dr. Prof. Rev.

First Name: _____ Middle Initial: _____ Last Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone:(_____) _____ - _____ Cell Phone:(_____) _____ - _____

Email: _____

Date of Birth _____/_____/_____ Gender: Male Female

Social Security Number _____ - _____ - _____

Marital Status: Single Married Widowed Other

Employment Status: Employed FT Student Other Retired Self Employed

Employer Data _____

Company Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____) _____ - _____ Is it okay to call you at work? Yes No

Spouse Data _____

Is your spouse a patient in the clinic? Yes No

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact _____

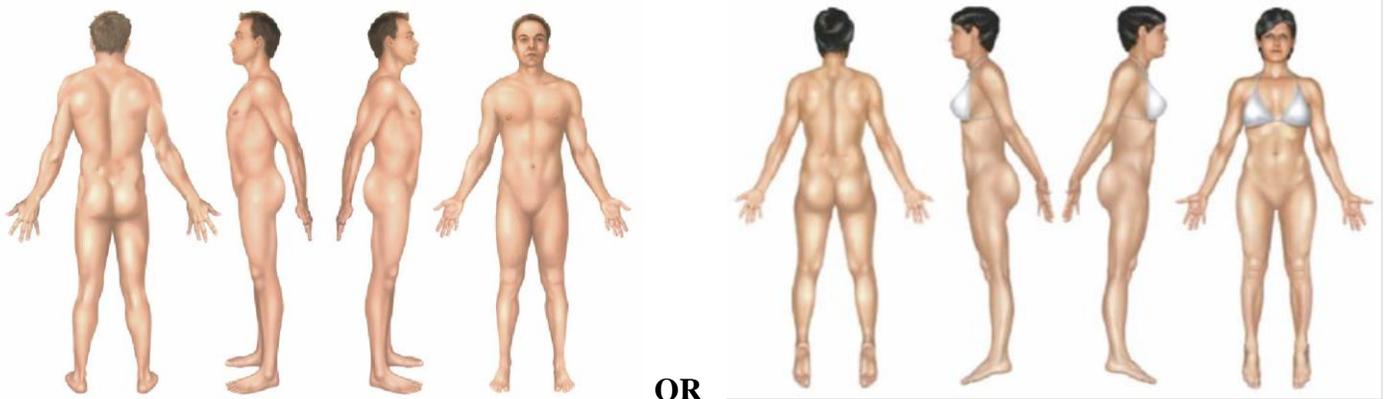
Contact Name: _____ Relationship to Patient: _____

Contact Phone Number: (_____) _____ - _____

PATIENT NAME: _____ DATE: _____

Indicate on the body diagram where you are experiencing the following symptoms:

= NUMBNESS X = BURNING / = STABBING 0 = PINS & NEEDLES + = DULL ACHE



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

CHECK the boxes that apply:

1. Is this a new condition? YES NO Have you experienced this before? YES NO
2. Pain Level(0 is no pain 10 is worst): 0 1 2 3 4 5 6 7 8 9 10
3. During the past 4 weeks, how much has pain interfered with your normal work and activities:
 None 1 2 3 4 5 6 7 8 9 10
4. During the past 4 weeks, indicate the average intensity of your symptoms
 None Minimum Mild Moderate Severe Unbearable
5. What describes the nature of your symptoms?
 Sharp Dull ache Numb Shooting Burning Tingling Stabbing
6. Does anything make the pain better?
 Acupuncture Chiropractic Therapy Heat Ice Massage Nothing Pain Medication Sleep
 Physical Therapy Stretching Other: _____
7. What is the frequency that you experience your symptoms?
 Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day)
 Intermittently (0-25% of the day) None
8. Are your symptoms improving/changing? Better Same Worse
9. Expectations: Become pain free Explanation of my condition Learn how to care for this condition on my own Reduce symptoms Resume Normal Activity

PATIENT NAME: _____

DATE: _____

In general, would you say your overall health right now is....

- Excellent Very good Good Fair Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist

Other _____

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery Other _____

When did you receive this treatment?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 – 2 years ago 2 – 5 years ago 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan Other _____

When were these tests done?

- In the last month 2 – 3 months ago 3 – 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 – 5 years ago 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist

Other _____

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer
 Homemaker Full-time Student Retired Other _____

If you are not retired, a homemaker or a student, what is your work status?

- Full-time Part-time Self-employed Unemployed Off work
 Other _____

How did you hear about our clinic? Or who referred you?

- | | | | |
|----------------------------------------|-------------------------------------------|--------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | |

If you selected 'family member', 'friend', or 'physician' please enter their name below:

PATIENT NAME: _____

DATE: _____

ONLY CHECK WHAT APPLIES TO YOU

Medical Conditions:

- Arthritis Cancer Diabetes Heart Disease
 Hypertension Psychiatric Illness Skin Disorder Stroke
 Other: _____

Surgeries:

- Appendectomy Cardiovascular procedure Cervical disc procedure Hysterectomy
 Joint replacement Laminectomies Radical prostatectomy Transurethral prostate surgery
 Other: _____

Allergies:

- Eggs Fish and Shellfish Milk or Lactose Peanut
 Soy Sulfites Wheat/Gluten Other: _____

Social History:

- Caffeine used occasionally Caffeine used often Chew tobacco occasionally Chew tobacco often
 Drink alcohol occasionally Drink alcohol often Exercise not at all Exercise occasionally
 Exercise often Experience stress occasionally Experience stress often Smoke 1 pack or less per day
 Smoke more than 1 pack a day Wear seat belts always Wear seat belts never Wear seatbelts usually

Family History:

- Arthritis (parent: mother or father) Arthritis (sibling) Cancer (parent: mother or father) Cancer (sibling)
 Cholesterol (parent: mother or father) Cholesterol (sibling) Diabetes (parent: mother of father) Diabetes (sibling)
 Heart problems (parent: mother or father) Heart problems (sibling) High blood pressure (parent: mother or father)
 High blood pressure (sibling) Psychiatric (parent: mother or father) Psychiatric (sibling)
 Stroke (parent: mother or father) Stroke (sibling) Thyroid (parent: mother or father) Thyroid (sibling)

Substance Use:

- Alcohol (past) Alcohol (present) Amphetamines (past) Amphetamines (present)
 Barbiturates (past) Barbiturates (present) Cocaine (past) Cocaine (present)
 Crystal Meth (past) Crystal Meth (present) Heroin (past) Heroin (Present)
 Marijuana (past) Marijuana (present)

Male Children: Under 6 years Under 10 years Under 19 years

Female Children: Under 6 years Under 10 years Under 19 years

Occupational Activities:

- Administration Business owner Clerical/secretarial Computer user Construction Daycare/childcare
 Executive/legal Food service industry Health care Heavy equipment operator Heavy manual labor
 Home services Household Light manual labor Manufacturing Medium manual labor

Recreational Activities:

- Backpacking Golf Soccer Weight Lifting Biking Racquetball Swimming
 Boating Running Tennis Football Football Skiing Walking

Revised Oswestry Back Pain Disability Questionnaire

Name: _____

Date: _____

*This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section **only the ONE box** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.*

Section 1: Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is very severe.
- F. The pain is severe and does not vary much.

Section 2: Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

Section 4: Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches
- F. I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more 10 minutes.
- F. Pain prevents me from sitting at all.

OTHER COMMENTS:

EXAMINER

Section 6: Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

Section 7: Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than 1/4.
- D. Because of pain, my normal night's sleep is reduced by less than 1/2.
- E. Because of pain, my normal night's sleep is reduced by less than 3/4.
- F. Pain prevents me from sleeping at all.

Section 8: Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

Section 9: Traveling

- A. I get no pain while travelling.
- B. I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- C. I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while travelling, which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Neck Disability Index Questionnaire

Name: _____

Date: _____

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.***

Section 1: Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

Section 2: Personal Care (washing, dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed; I wash with difficulty and stay in bed.

Section 3: Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

Section 4: Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

Section 5: Headaches

- G. I have no headaches at all.
- H. I have slight headaches which come infrequently.
- I. I have moderate headaches which come infrequently.
- J. I have moderate headaches which come frequently.
- K. I have severe headaches which come frequently.
- L. I have headaches almost all the time.

Section 6: Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

Section 7: Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

Section 8: Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

Section 9: Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10: Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

OTHER COMMENTS:

EXAMINER

REVIEW OF SYSTEMS
Have you had trouble with any of the following?

NAME: _____ **DATE:** _____

<u>COSTITUTIONAL</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	<u>MUSCULOSKELETAL</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Weight loss/gain				Gout			
Energy level problem				Arthritis			
Difficulty sleeping				Joint Stiffness			
<u>EYES</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	<u>INTEGUMENTARY (skin and or breast)</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Glaucoma				Skin Ulcers			
Double Vision				Skin Disease			
Blurred Vision				Eczema			
<u>EARS/NOSE/THROAT</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	Psoriasis			
Dizziness				Rashes			
Hearing Loss				<u>NEUROLOGICAL</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Sinus Infection				Stroke			
Nosebleed				Seizures			
Sore Throat				Head Injury			
Difficulty Swallowing				Brain Aneurysm			
Bleeding Gums				Numbness			
<u>CARDIOVASULAR</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	Severe Headaches			
Poor Circulation				Pinched Nerves			
High Blood Pressure				Parkinson's Disease			
Aortic Aneurism				Carpal Tunnel			
Heart Disease				Spinning/Balance			
Heart Attack				<u>Psychiatric</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Chest Pain				Depression			
High Cholesterol				Anxiety Disorder			
Pace Maker				Unusual Stress			
Jaw Pain				<u>ENDOCRINE</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Irregular Heartbeat				Thyroid Disease			
Swelling of Legs				Diabetes			
<u>RESPIATORY</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	Hair Loss			
Asthma				Menopausal			
Tuberculosis				Menstrual Problems			
Shortness of Breath				<u>Hematologic/lymphatic</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Emphysema				Hepatitis			
Cold/Flu				Blood Clots			
Cough/Wheezing				Cancer			
<u>GASTROINTESTINAL</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	Easy Bruising			
Gallbladder Problems				Easy Bleeding			
Bowel Problems				Fevers/Chills/Sweats			
Constipation				<u>ALLERGIC/IMMUNOLOGIC</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
Liver Problems				Hives			
Ulcers				Immune Disorder			
Diarrhea				HIV/AIDS			
Nausea/Vomiting				Allergy Shots			
Bloody Stools				Cortisone Use			
Poor Appetite				<u>MUSCLE WEAKNESS</u>	<u>Present</u>	<u>Past</u>	<u>No</u>
<u>GENITOURINARY</u>	<u>Present</u>	<u>Past</u>	<u>No</u>	Osteoporosis			
Kidney Disease				Broken Bones			
Lower Side Pain				Joints Replaced			
Burning/Frequent Urination							
Blood in Urine							
Kidney Stones							

**Family Chiropractic
400 Biltmore Drive
Suite 407
Fenton, MO 63026
P: 636-305-3400 / F: 636-305-3480**

INSURANCE INFORMATION:

Primary Insurance: _____

Name of Insured/Policy Holder: _____

ID/Member Number: _____ **Group Number:** _____

Date of Birth for Policy Holder: _____

Secondary Insurance: _____

Name of Insured/Policy Holder: _____

ID/Member Number: _____ **Group Number:** _____

Date of Birth for Policy Holder: _____

If an Auto Accident Please Provide:

Insurance Company Name: _____

Contact Person/Claims Adjuster: _____ **Phone:** _____

Claim Number: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ **Date:** _____

Spouse's or Guardian's Signature: _____ **Date:** _____

Family Chiropractic Financial Policy

Medicare covers medically necessary spinal manipulations. All other services are considered non-covered by Medicare. When you reach the point in your treatment where no further functional improvement is expected, Medicare considers your care at that point to be maintenance care and will no longer cover it. We will discuss it with you and have you sign a special form when you reach that point but as long as we can expect improved function, Medicare considers your care necessary. Exams, x-rays and therapy are not covered services. Payments for non-covered services are due at the time of service.

Most Medicare supplemental plans cover only what Medicare allows. There are a few secondary insurances that cover services not covered by Medicare. As a service to you, we call your insurance company to verify your coverage. **Initial** _____

Medicare Advantage Programs****Referrals are required for some plans and coverage varies. We will call to verify your benefits.

Group Insurance We are a provider for most plans. Most plans cover chiropractic. If your plan requires a referral, it is your responsibility to call your doctor and ask for the referral to be sent to us. Our fax number is 636-305-3480. After the initial referral, most doctors will allow us to call directly to get further visits approved but we ask you to keep track of your approved visits and call you doctor when you need more. We expect you to pay for your co-pay at the time of services. If you have a deductible or co-insurance we expect you to pay at the time of service or have other payment arrangements made.

As a service to you we will verify you coverage for you. We will need a copy of your insurance card. We are not responsible for improper quoting of benefits by your insurance company. We do, however, do everything we can to get your claims processed properly. **Initial** _____

Personal Injury Cases or Automobile Accidents Please present your insurance cards as soon as possible and a claim number. If you have an attorney please let the office know as soon as possible. It is our policy that your Medical Payments* portion of your car insurance be billed as your primary insurance. (*Medical Payment is part of your auto insurance that you pay extra for that is not held against you in case of an accident and does not matter whose fault the accident was.) Med Pay will pay for services as you go. Med Pay pays in addition to any settlement you get when your case is settled. If your med-pay does not cover your total bill then your secondary payer will be the liability company. We do not accept provider discounts because your automobile medical payments are considered primary and all other companies are secondary. If you suspend or terminate care fees are due immediately. We will contact your attorney and insurance company when you are released from active care to begin settlement procedures. We will send a lien to your attorney or the insurance company of whoever caused the accident to cover any unpaid balance at the end of care. At any point settlement is reached, your account is due and payable immediately. If your case is not settled within 90 days of release of care, we will require you begin payment on the outstanding balance.

The "liability insurance" is the company of the person who was at fault in the accident. Liability insurance does not pay until treatment is complete and you sign the settlement paperwork that closes the case. We will need to get a claim number and address of the responsible company in order to bill them. We will ask you to sign an assignment of benefits and send a lien so that our bill will be paid directly. We will send in your billing to them at the end of your treatment. You will need to notify them when your treatment is complete so they can start the settlement process.

We do not bill health insurance unless there is no med-pay and no third party that is liable. If you use your health insurance copays have to be paid at the time of service. **Initial** _____

Patients without Insurance We treat many patients who have no insurance. Our goal is to help you at whatever level of care you desire. We have many cash patients who want to receive the care they need to resolve their health issues and others who feel they just want some relief. Of course, the best choice for your health is getting the problem corrected and doing the necessary rehabilitative exercises but sometimes it is not the right time for the cost and time necessary to follow through. We are here to help you. Payment is expected at the time of service. We do offer a discount on some services if you pay at the time of service. If you cannot pay at the time of service, we can make payment arrangements. If you would like to make payment arrangements, our front desk administrator will discuss it with you. **Initial** _____

***Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics and nutritional supplements at the time they are provided. ***If any account is turned over for collections all attorney fees, court costs, interest, all collection fees and all cost associated with the collection of your account will be in addition to the account balance.

Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Family Chiropractic Office

Financial Responsibility

I have requested professional services from Dr. Margaret Freihaut, DBA/Family Chiropractic Office, on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Dr. Freihaut. I certify that the health insurance information that I provided to Dr. Freihaut is accurate as of the date set forth below and that I am responsible for keeping it update.

I hereby authorize Dr. Freihaut to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Dr. Freihaut, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Dr. Freihaut directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Dr. Freihaut, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Dr. Freihaut upon request. Upon Proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Dr. Freihaut.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Dr. Freihaut are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Dr. Freihaut to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Dr. Freihaut to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my authorized representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my authorized representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my authorized representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Dr. Freihaut and, to the extent permissible under law, to claim on my behalf, such benefits, claims, rights, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ Date _____
Patient

_____ Date _____
Policy holder/insured