Rockford Chiropractic Clinic

Rockford Chiropractic Clinic - Insurance Intake Form

Today's Date: ___________________

First Name:___________________________ Last Name:________________________________

Phone Number:________________________ Email:____________________________________

Address:_______________________________ Occupation:_______________________________

City:__________________________________ Sex (Choose one): ◻ Male ◻ Female

State:__________________________________ Marital Status:______________________ _______

Zip:___________________________________ Date of Birth:______________________________

How did you find out about this office?____

Insurance Company: ____

Insurance #: __________________________________ **Group #**: _______________________________

Who is responsible for this account? (circle one) Self / Spouse / Parent or Guardian

Subscribers Name: ____ **DOB**: _____/______/_______

Assignment and Release: I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to Rockford Chiropractic Clinic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance forms.

Responsible Party Signature: __________________________ **Date**: ____/____/_____

Insurance Billed Rates:

- **Deductible** and **co-payments** are **the responsibility of the patient.**
- New patient visits range from $75 to $120. Follow-up adjustments range between $35 to $55.
- All insurance companies have a standard fee schedule for billed Chiropractic Services. We will do our best to estimate your insurance cost, however estimates are not guaranteed.
- Insurance companies follow Medicare Guidelines.
- We will file your insurance claims for you and collect insurance payments for services that are covered.
- **Most insurance companies do not pay for exams or additional therapies.**
- If you choose to receive **services that are not covered or rejected** by your insurance, **you will be responsible** for the Time-of-Service Rates for those services.

Patient Agreement: I have read, understood, agreed to, and received a copy of this agreement (if requested) I understand that prices are subject to change, and notification occurs via posted in the office.

Signature: ____ Date: ____________________

Office use Only:

Authorization date range: _____________ to _______________ for _________ visits

<u>Consent to Initiate Care – Insurance Patients</u>

At Rockford Chiropractic Clinic there is one simple goal, to provide the highest quality chiropractic adjustments at the lowest possible fees. To accomplish this goal, we have implemented specific office procedures. Please read over these procedures along with the benefits/risks of chiropractic adjustments below to understand how the office functions and to decide if you wish to participate. If you have any questions, please direct them to us in person or by phone anytime.

- Insurance companies follow <u>Medicare Guidelines</u>. <u>By law</u>, <u>we</u> need to follow these rules <u>and</u> <u>the patient must agree to follow these rules</u> to receive care with the insurance. Otherwise, you and I will be committing insurance fraud. The rules are as follows:
    - Insurance can only be used for acute and/or chronic conditions. **No maintenance visits.** The initial visit must demonstrate a need for care. The patient can record a pain greater than 6 to accomplish this goal.

      Medicare ABN
      PT Int: _____

    - Insurances require a 3–6-month(s) care plan of weekly visits. Typical chiropractic care plans are for 10-20 visits with 2-3x per week for the first month(s), followed by weekly visits for the following month(s). This is prescheduled. Failure to comply with schedule requirements will negate obligation to bill insurance and you will be billed our cash rate.

      PT Int: _____

    - Symptom and condition relief must be documented. The pain levels should reduce over the course of the care plan.
- **<u>Deductibles and co-payments are due at the time of service.</u>**
- Rockford Chiropractic Clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the member's health is not being best served.
- By signing below, you understand that chiropractic adjustments are for the purpose of wellness and spinal hygiene to detect and improve subluxations within the musculoskeletal system. Adjustments are performed to help the body heal more efficiently. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.
- By signing below, you also agree to the understanding that any intervention, including chiropractic adjustments, come with inherent risks and/or benefits. While rare it is possible to sustain injuries including but not limited to muscular soreness, sprain/strains, fractures, dislocations, disc injuries, and stroke following a chiropractic adjustment.

I have read the Consent to Initiate care statements above, understand the procedures of the office as well as the benefits and risks of chiropractic adjustments and wish to initiate care at this office. I also understand that I am under no obligation to receive or continue care if I so choose.

Print your name: _______________________________ **Date:** ______________________

Sign your name: _______________________________

PLEASE SEE NEXT PAGE FOR ADDITIONAL QUESTIONS

QUESTIONS TO GET US STARTED

List the issues that bring you into the office:

____

For each issue, when did it start?

____

For each issue, how did it start?

____

For each issue, what relieves it/makes it better?

____

For each issue, describe the symptoms (achy, dull, shooting, etc.):

____

For each issue, do you have tingling/numbness/shooting anywhere? Down one or more arms/legs?

____

For each issue, rate severity 1-10 (10 being worst):

____

For each issue, note the time of day it is the worst? If constant, write constant:

____

For each issue, list the activities/hobbies you have been unable to do because of your problem:

____

For each issue, list the doctors/therapists you have seen (ex: medication, therapy, etc.):

____

When was the last time you had images of your spine taken (Xray, MRI, CT scan)?

____

Have you ever been to a chiropractor or been adjusted before?

____

PLEASE SEE NEXT PAGE FOR ADDITIONAL QUESTIONS

List any surgeries you've had and year each occurred:

____

List any significant injuries you've had and year each occurred:

____

List any significant disease in your immediate family (ex: heart, lung, digestive, skin, autoimmune, etc.):

____

List any significant health problems you currently have (ex: heart, lung, digestive, skin, , etc.):

____

What activities do you partake in most often daily (ex: sit at a desk, stand, bend, lift, twist)?

____

A Few More Questions

1. Do you drink ½ gallon + of clean water a day? □ Yes □ No
2. Do you eat 100g + of protein a day? □ Yes □ No
    a. Do you take collagen peptides? □ Yes □ No
3. Do you eat 6 servings of vegetables or use greens each day? □ Yes □ No
4. Do you exercise and move your body on a daily basis? □ Yes □ No
    a. Do you go outside regularly? □ Yes □ No
5. Do you consume less than 23g of sugar a day? □ Yes □ No
6. Do you meditate, pray, or do breathwork daily? □ Yes □ No

What are you hoping to achieve by coming to Rockford Chiropractic Clinic?

□ **Symptom relief** – relief of pain through chiropractic adjustments.

□ **Wellness** – routine adjustments for improved wellness/healing.

□ **Relief with transition to wellness**

□ **Unsure** – I'd like you to help me select what is appropriate.

Office Use:

LBP	UBP	SH L / R	Pelvis	Mid Back	Neck