APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: _____ Today's Date: ____/____/____

Address: _____ City/State/Zip: _____

E-mail Address: _____

Birth Date: ___/___/___ Age: _____ Are you Pregnant: ❒ Yes ❒ No

Employer's Name & Address: _____

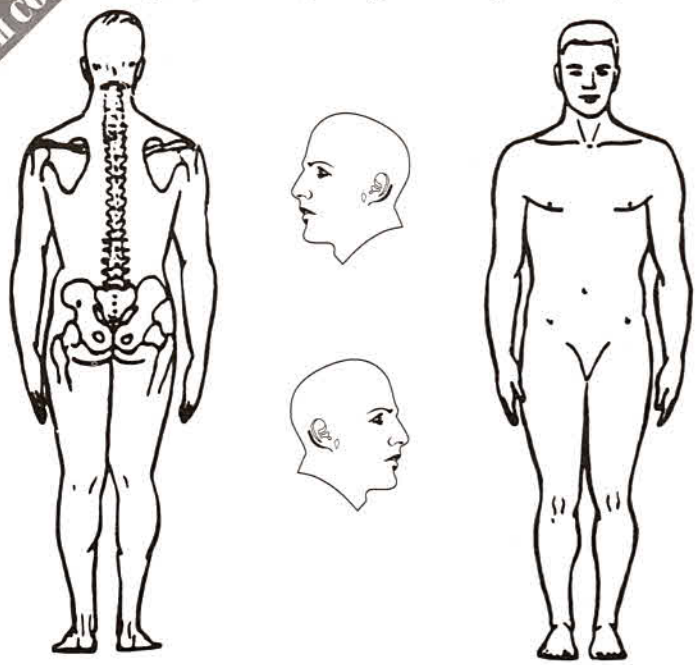
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____

Who referred you to our office: _____

What type of care do you desire: ❒ Temporary Relief ❒ Lasting Correction ❒ Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:

1) _____
2) _____
3) _____
4) _____
5) _____

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

1) _____
2) _____
3) _____
4) _____
5) _____

When was the first time you noticed this problem:

_____

_____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: _____

_____

Have you had any similar health problems or injuries before? ❒ Yes ❒ No If yes, please explain: _____

_____

Names of all other doctors you have seen for this problem: _____

_____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

_____

_____

Has your health problem been: ❒ Improving ❒ Worsening ❒ Staying the Same

Please describe anything you do that improves your condition, or worsens it: _____

_____

Please check off and describe how this problem interferes with your work and/or personal life:

❒ Home Activities Effected: _____

❒ Work Activities Effected: _____

Have you missed any work days? ❒ Yes ❒ No If yes, dates missed: _____

❒ Recreational Activities Effected: _____

❒ Rest or Sleep Effected: _____

(Please complete reverse side.)

PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ❒ Yes ❒ No
If yes, please explain: _____

_____

_____

Have you ever received Chiropractic care? ❒ Yes ❒ No If yes, please list the doctor's name, location of office and for what problems: _____

_____

_____

Please check off the drugs you are now taking: ❒ Pain Killers ❒ Muscle Relaxers ❒ Anti-inflammatory
❒ Blood Pressure Medication ❒ Insulin ❒ Birth Control Pills ❒ Tranquilizers ❒ Diet Pills
❒ Nerve Medication ❒ Sleeping Pills ❒ Anti-depressants ❒ Other (please list): _____

_____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

_____

_____

If you have been in an automobile accident, when? ❒ This Year ❒ Last Year ❒ Past 5 Years ❒ Over 5 Years

Please check off the following that apply to you within the past 2 years: ❒ Went to a Health Spa
❒ Purchased Vitamins ❒ Purchased Health Foods ❒ Received a Massage
Please explain why you choose to do any of the above: _____

_____

FAMILY HEALTH HISTORY

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Separated

Names & Ages of Children: _____

Name of wife or husband: _____

Spouse's Employer: _____ Business Phone: _____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ❒ I am ❒ Spouse (Spouse's Birthdate: ____/____/ ____)
❒ My Employer ❒ Insurance ❒ Other: _____

Type of Insurance: ❒ Worker's Comp. ❒ Health ❒ Automobile

Insurance Company's Name & Address: _____

_____

If you are responsible for your health care fees, payment will be made by: ❒ Cash ❒ Check ❒ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature _____ Social Security No: _____ Date: ____/____/____

Patient Name:_____ Number_____ HWBP_____ Chiropad_____

Activities of Daily Living

Please circle all of the activities below that are affected by your condition. (Those activities that you cannot do or avoid performing, that cause you pain or aggravate your condition when performed.)

General:

- Bending
- Chewing
- Climbing stairs
- Exercising
- Getting in/out of auto
- Getting out of a chair
- Kneeling
- Lifting
- Lifting children
- Lying in bed
- Playing piano
- Reaching behind
- Reaching overhead
- Reading
- Running
- Sexual intercourse
- Sitting
- Sitting in recliner
- Sleeping
- Standing
- Swimming
- Using telephone
- Using typewriter/computer
- Walking

Exercise:

- Baseball
- Basketball
- Cycling
- Golf
- Hockey
- Lifting weights
- Running
- Soccer
- Tennis
- Working out in Gym

Housework:

- Caring for pets
- Carrying groceries
- Cooking
- Doing Laundry
- Dusting
- Ironing
- Making beds
- Vacuuming
- Washing dishes

Personal Grooming:

- Brushing teeth
- Combing hair
- In/out bathtub
- Putting on bra
- Putting on socks
- Shaving

Travel:

- Driving
- Flying
- Riding (passenger)

Yard work:

- Gardening
- Hammering
- Mowing lawn
- Painting
- Raking leaves
- Sawing

Patient's signature: _____Date:_____

For Office Use Only

Smoker _____ Non Smoker _____ Former Smoker_____ H _____ W _____ BP _____ P _____

Health _____

ADL's _____

Prescriptions

Medication

- Active NKM _____
- Allergies NKDA _____

Nutrition

- Active NKNS _____
- Allergies NKNA _____

FAMILY HEALTH HISTORY

To help the doctor determine if your health problem is hereditary: 1) please check off (✓) the health problems of your family members; 2) leave blank those health problems they don't have; 3) circle those relatives who live within 30 miles of you, as some hereditary conditions are affected by a similar climate.

Patient Name: _____ **Date:** _____

HEALTH PROBLEM	MOTHER Age ( )	FATHER Age ( )	BROTHER(S) Age ( )	BROTHER(S) Age ( )	SISTER(S) Age ( )	SISTER(S) Age ( )	SPOUSE Age ( )	CHILDREN Age ( )	CHILDREN Age ( )	CHILDREN Age ( )
Allergies										
Arm Pain – Numbness/Tingling										
Arthritis										
Asthma										
Back Pain										
Bursitis, Tendinitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Hand Pain – Numbness/Tingling										
Hay Fever										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Leg Pain – Numbness/Tingling										
Liver Trouble										
Low Blood Pressure										
Migraine										
Neck Pain										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerves										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Stomach Trouble										
Whiplash										

If any of your immediate family members (Mother, Father, brother, sister, or children) are deceased, please list their age at death and cause: _____

_____

_____

Dr. Gerald A.Nadeau - Dr. Robert G. Nadeau - Dr. Daniel R. Nadeau

336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ office@nadeauchiro.com

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ Date of Birth:_____

Address:_____

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

Email Address:_____

I,_____ authorize Nadeau Chiropractic Associates to discuss Information pertaining to my appointments, treatments, financial matters and In case of an Emergency to:

Name: _____

Phone Number: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Nadeau Chiropractic Associates. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow up among the healthcare providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third party payers.Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that the notice describes the uses and disclosures of my protected health information by Nadeau Chiropractic Associates and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or legal Representative Today's Date

_____ _____

Print Name of Patients Representative Legal Representative Relationship

FOR OFFICE USE

We have made every effort to obtain written acknowledgement of receipt of out Notice of Privacy from this patient but it could not be obtained because:

___ The patient refused to sign ___ Due to emergency situation it was not possible to obtain an acknowledgement ___Communication barriers prohibited obtaining the acknowledgement

Patient Financial Responsibility Agreement

Patient Information:

- Name: _____ DOB: _____
- Address: _____
- Phone: _____ Email: _____

Insurance Information:

- Primary Insurance: _____ Policy #: _____
- Group #: _____ Secondary Insurance (if any): _____
- Policy #: _____ Group #: _____

Acknowledgement of Financial Responsibility:

I, the undersigned, agree to the following:

1. **Insurance Coverage**: I will provide accurate and current insurance information. I understand that the office will bill my insurance as a courtesy, but I am ultimately responsible for payment.

2. **Non-Covered Services**: I am responsible for any services not covered by my insurance.

3. **Insurance Denials**: If my insurance denies any part of my claim or does not pay promptly, I am responsible for the outstanding balance.

4. **Payment Terms**: I will pay any co-pays, deductibles, co-insurances, and other non-covered charges at the time of service or upon receiving a billing statement.

5. **Collections**: If my account is delinquent, it may be sent to a collection agency, and I will be responsible for additional costs, including collection and legal fees.

Authorization and Agreement: I have read, understood, and agree to the terms of this financial responsibility agreement. I authorize the release of necessary medical information to process my claims and payment of medical benefits to the office for services rendered.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Office Use Only:

Received By: _____ Date Received: _____

NADEAU CHIROPRACTIC ASSOCIATES
Dr. Gerald A. Nadeau - Dr. Robert G. Nadeau
336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ drgnadeau@gmail.com

Notice of Receipt of Privacy Notice of Nadeau Chiropractic Associates

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Nadeau Chiropractic Associates, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

_____ _____
Name of Individual (printed) Signature of Individual

_____ _____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor): Relationship

Date Signed ____/____/____ Witness:_____

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Irrevocable
Assignment, Lien and Authorization
Insurance Benefits and Attorney

To Whom it May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly **Nadeau Chiropractic Associates** such sums may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reasons of any other bills that are due this Office, and to withhold such a sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on behalf as may be necessary to adequately protect said Office. I hereby further give lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event that my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payment, upon demand by me of this Office, I hear by assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collecting collections under the Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse the Office for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

Signed_____Date:_____

Witness:_____Date:_____

VERIFICATION OF INSURANCE COVERAGE

Nadeau Chiropractic Associates _____ Date/Time _____

PATIENT INFORMATION

Name: _____ DOB: _____ Patient # _____

Relationship to Insured: Self ___ Spouse ___ Child ___

INSURED INFORMATION (POLICY HOLDER)

Name: _____ TID# _____

DOB: _____ Group # _____

INSURANCE PAYER INFORMATION

Carrier Name: _____

Name of Insurance Representative: _____

Phone: _____ Electronic Claims to _____

Mail Claims to: _____

COVERAGE DETAILS

Effective Date: _____
Referral Needed: __ Yes __ No
Deductible: __Yes __ No Amount: $_____
Met? __ Yes __ No Next Due _____
Copay: $% _____
X-Rays Covered: __ Yes __ No
Out of Pocket Amount: $_____
Visit Limit: _____

CPT CODE COVERAGE

97140 Manual Therapy	__ Yes __ No
98943 M8	__ Yes __ No
29200 – 29500	__ Yes __ No
99201 – 99204	__ Yes __ No
Taping Codes	__ Yes __ No

BENEFITS SUMMARY

Pre-Existing Conditions: __ Yes __ No
Carryover Clause for Deductible: __ Yes __ No

REPORTING REQUIREMENTS

Special Reports Needed: __ Yes __ No If yes, when _____

The Doctor's treatment plan will be based upon what he determines is in the best interest for your health and benefit. Please note: We have no influence over your insurance company's reimbursement policies or rationales for denials. We will report clinical information to your Primary Care Physician and insurance company to ensure maximum benefit reimbursement. However, please be aware that you will be responsible for the cost if your insurance company limits the number of adjustments, exams or services, (ie: modalities, exercises, etc.).

We recommend that you verify your chiropractic insurance coverage as well.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____