

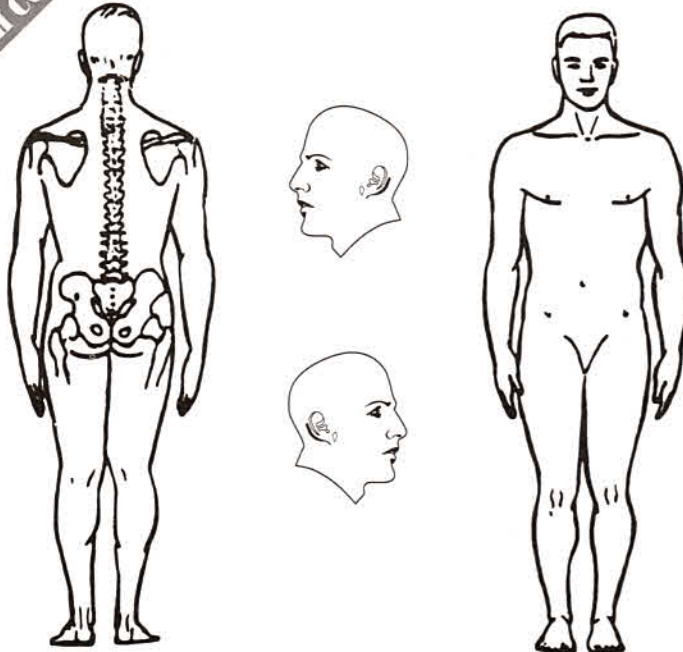
APPLICATION FOR TREATMENT

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 _____ Chiroprad _____

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	FATHER	BROTHER(S)		SISTER(S)		SPOUSE	CHILDREN		
	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	Age ()	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 our 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 applicable): _____

Policy #: _____ Group #: _____

TERMS AND CONDITIONS

By signing this document (signature on Page 2), I, the patient or legal representative, acknowledge and agree:

1. **Insurance Coverage & Verification**
Insurance billing is a courtesy. Verification of benefits is **not** a guarantee of payment. Coverage determinations are made solely by the insurance carrier, and I am financially responsible for all charges regardless of quoted benefits or estimates.
2. **Non-Covered Services**
I am responsible for all services not covered by my insurance plan.
3. **Insurance Denials or Delays**
If my insurance carrier denies, reduces, or delays payment, I am responsible for the remaining balance.
4. **Payment Terms**
Co-payments, deductibles, co-insurance, and non-covered charges are due **at the time of service** or **within 30 days** of the billing statement date.
5. **Assignment of Benefits**
I assign all applicable medical and insurance benefits payable for services rendered to **Nadeau Chiropractic Associates**.
6. **Collections**
Unpaid balances may be sent to a collection agency. I agree to be responsible for reasonable collection costs, including collection agency fees, attorney fees, and court costs, as permitted by law.
7. **Returned or Failed Payments**
A fee may be charged for returned checks or failed electronic payments, as permitted by law.
8. **Emergency After-Hours Fee**
By requesting and receiving care outside normal office hours (evenings, weekends, or holidays), I agree to an **Emergency After-Hours Fee of \$40.00**, due at the time of service, **payable in cash**. This fee is separate from professional service charges and is **not billable to insurance**.

AUTHORIZATION (Insurance Processing)

I authorize the release of necessary medical information for insurance processing and authorize payment of insurance benefits directly to the office.

Nadeau Chiropractic Associates

336 Center St., Auburn, ME 04210

T: (207) 777-1104 F: (207) 777-7354 office@nadeauchiro.com

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

I acknowledge that I have received and had the opportunity to review the **Notice of Privacy Practices** for Nadeau Chiropractic Associates. I understand my protected health information may be used and disclosed for:

- Treatment coordination and management
 - Payment activities and billing
 - Healthcare operations (e.g., quality assessment, accreditation)
-

AUTHORIZATION TO DISCUSS INFORMATION (Optional)

☐ **I DO NOT authorize** Nadeau Chiropractic Associates to discuss my appointments, treatment, or financial matters with anyone other than myself.

☐ **I DO authorize** Nadeau Chiropractic Associates to discuss my appointments, treatment, and financial matters, and in the event of an emergency, with:

Name: _____

Phone: _____

SINGLE SIGNATURE FOR ENTIRE DOCUMENT (PAGES 1–2)

By signing below, I confirm that I have read, understand, and agree to **all terms and authorizations in this document**, including the **Patient Financial Responsibility Agreement** (Page 1), the **Emergency After-Hours Fee**, the **Authorization for Insurance Processing**, and the **Notice of Privacy Practices acknowledgement** (Page 2). This signature applies to **both pages**.

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to Patient (if applicable): _____

FOR OFFICE USE ONLY

We made a good-faith effort to obtain acknowledgement, but it could not be obtained because:

- ☐ Patient refused to sign
- ☐ Emergency situation prevented acknowledgement
- ☐ Communication barriers prevented acknowledgement



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:_____



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

**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: _____