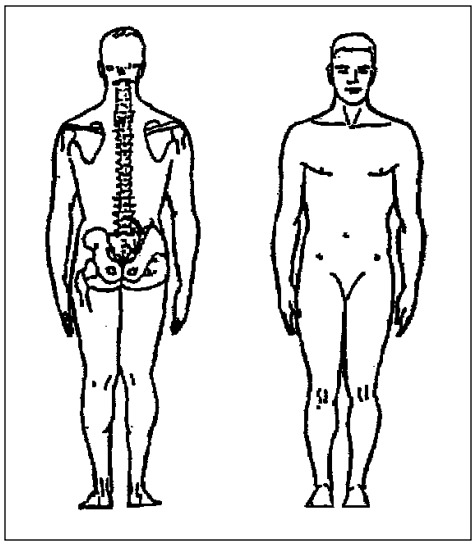
Back On Track Chiropractic – Patient Information

Name_____ Birthdate_____ Age___
Home Phone_____ Cell _____ Work_____ SSN #_____
Address_____ City_____ State___ Zip_____
E-mail Address_____ Marital Status – S M W D # of Children_____
Your Employer _____Occupation_____ Years on Job___
Employer Address _____City_____ State ___ Zip_____
Spouse/Parent Name_____ Birthdate_____ Phone #_____
Spouse/Parent Employer_____ Phone #_____ Occupation_____

Insurance Information

Insurance Co. Name_____ ID #_____
Name of Subscriber _____Subscriber Date of Birth_____
Subscriber SSN# (if different from Above) _____



Complete the Diagram

If you are in pain, please mark the exact location of your pain on the diagram. Please list any condition(s) you are being treated for or are experiencing:

_____
_____
_____

Other Health Information

Primary Doctor's Name_____
Phone # _____
Is your condition due to an accident? Yes or No
Date of Accident _____
Type of accident? Auto/Work Related/ Home/Other _____
Have you ever been in an auto accident? Past Year/Past 5 Years/Over 5 years ago
Who can we thank for referring you to our office? _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.
Full Payment for services rendered is due at the end of each visit.

Patient/Guardian Signature: _____ Date: _____

Name _____ **Date** _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

- ☐ Allergy
- ☐ Chills/Sweats
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness/depression
- ☐ Neuralgia
- ☐ Numbness
- ☐ Tremors

MUSCLE & JOINT

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Hernia
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Painful tail bone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen joints

Pain or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

GASTRO-INTESTINAL

- ☐ Belching or gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Distension of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT

- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Far Sightedness
- ☐ Near Sightedness
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis

CARDIO-VASCULAR

- ☐ Hardening of arteries
- ☐ High/Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid/Slow heart beat
- ☐ Swelling of ankles

RESPIRATORY

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing

SKIN

- ☐ Bruise easily
- ☐ Dryness/Itching
- ☐ Hives or allergy
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

GENITO-URINARY

- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble

FOR WOMEN ONLY

- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge

☐ Yes ☐ No **Are you pregnant?**

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Multiple sclerosis	☐ Shingles
☐ Anemia	☐ Diabetes	☐ Gout	☐ Mumps	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Pleurisy	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pneumonia	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Malaria	☐ Polio	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic fever	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Miscarriage	☐ Scarlet fever	☐ Whooping cough

List surgical operation and years: _____

_____

Date of Last: Physical Examination_____ X-Ray_____

HAVE YOU EVER:	**YES**	**NO**	**Briefly Describe:**
Been treated for a mental disease?	☐	☐	_____
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine/nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized, other than for surgery?	☐	☐	_____

EMERGENCY Contact: (Not living in your home): Name: _____Phone: _____

Electronic Health Records Form

Name: _____ **DOB**: _____

Email: _____

Preferred Method of Communication: Email/Phone/Mail

Preferred Language: English/Other _____

Smoking Status: Everyday / Occasional /Former /Never

Race (Circle One): White (Caucasian) / American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Full Medication List (Vitamins Included):

_____

_____

_____

☐ **I would like receipt of my clinical summary after every visit**. (These summaries are often blank as a result of the nature and frequency of Chiropractic Care.)

Patient/Guardian Signature: _____ Date: _____

Authorization, Assignment & Release Form

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collections and/or recovery in this State of Missouri.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continued effect until revoked by both parties.

Patient/Insured Signature_____ Date_____

Privacy Practices

I have received or reviewed the privacy practice notice (3 pages) for Back on Track Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records.

I understand that this office will properly maintain my records, and will use all means to protect my privacy as outlined in this privacy practice statement.

Patient Signature_____Date_____

Print the Patients Name_____

Witness_____ Date _____

Office Financial Policy

Cash

1. All patients are on a cash basis until their respective insurance coverage and deductible has been verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

Insurance

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you: you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility. Except PPO discounts.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately; regardless of any claims submitted.
8. If you have questions concerning this or any other matter, please speak with the receptionist or office manager prior to seeing the Doctor.

   All patients who have an unpaid balance on their account with no attempt to pay off debt within 30 days of notice from our office will be referred to a collection agency. Patients of the unpaid account will be responsible for paying all debt and collection fees that occur.

Thank you,
Doctors & Staff of Back on Track Chiropractic

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date