Chiropractic Case History

Name_____ Sex M F Date_____

Address_____ City_____ State_____ Zip_____

H. Phone(_____)_____ W. Phone_____ Cell Phone _____

Date of Birth_____ Age_____

Would you like to be signed up for text message or e-mail reminders? Yes No

Who is your cell phone carrier? _____ What is your e-mail address? _____

Primary Dr._____ Social Security #_____

Occupation_____ Employer_____

Marital Status: _____ Spouse Name: _____ Spouse Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

Is your visit related to an open worker's comp or no fault claim? Yes No

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

3. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication | Reason for taking

_____

_____

_____

E. Surgeries:

Date | Type of Surgery

_____ | _____

_____ | _____

_____ | _____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery | Outcome

_____ | _____

_____ | _____

_____ | _____

4. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death | Age at death

_____ | _____

_____ | _____

_____ | _____

5. Social and Occupational History:

A. Job description: _____

B. Recreational activities: _____

C. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

❑ Yellow Pages ❑ Website ❑ Google Search ❑ MD Referral ❑ Facebook ❑ Patient Referral ❑ Returning Old Patient
❑ Friend/family ❑ Advertisement

Name: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Lifetime Insurance Authorization

Provider Name: Jeffrey Patterson

I authorize the release of any medical information necessary to process claims. I authorize payments under my insurance programs to be made directly to the above provider for any services furnished to me. This authorization will remain in effect indefinitely unless revoked by me in writing. I further permit copies of the authorization to be used in place of the original.

Billing services are provided on location. Full payment for services rendered by Jeffrey Patterson, D.C. is due within three months of the date the service is rendered, unless other arrangements are made in advance. Failure to comply with this agreement gives the provider the right to turn outstanding charges over to a private collection agency. My signature on this form verifies that I understand this agreement and will comply with the same.

Further more, I acknowledge that I have received a copy of the Notice of Privacy Practices for Chemung Chiropractic.

Patient Signature (or responsible party):_____

Print Name:_____ Date:_____

FOR BILLING QUESTIONS CALL: 607-796-2150

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Chemung Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatments, will be explained to me upon my request.

Patient Signature:_____ Date:_____

PAYMENT POLICY

Thank you for choosing Chemung Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not canceled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**