Fairbanks Chiropractic Clinic
1118 2nd Avenue
Fairbanks, AK 99701
907-456-6213

Full Name: _____
First **M.I.** **Last**

Address: _____
Street **City** **State** **Zip**

Birth Date:___/___/___**Male Female**

Email Address:_____

Phone Number:_____**Home/ Cell/ Work**

I am (circle) **Minor/Single/Married/Divorced/Widowed/Separated**

Who referred you to us?_____ (Free t-shirt to those who referred you)

Emergency Contact:_____ **Phone Number:**_____

Insurance Information

Do you have health insurance?_____Yes_____No **CASH PATIENT: Y/N**
Insurance Policy Holder's Name:_____ Birth Date:_____/_____/_____
Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Fairbanks Chiropractic Clinic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Fairbanks Chiropractic Clinic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed_____Date _____

Health Questionnaire

List all prescription, non-prescription medications and other supplements you take as well as the associated condition:

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

List all allergies: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): _____

Do you exercise? **Y N** Hours per week_____ Are you dieting? **Y N** Since:_____

Do you smoke? **Y N** How Long?_____Alcoholic beverages? **Y N** ___drinks per day.

Do you wear? Heel lifts Arch supports Prescription Orthotics

For women: Are you pregnant or nursing? **Y N** If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

Are you here because of an accident? **Y N** What type? _____

When did your symptoms start? ____/____/____ How did your symptoms begin? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

How do your symptoms interfere with your work or normal activities?_____

_____

Have you experienced these symptoms in the past?_____

History of Treatment

Primary care physician:_____Phone: _____

Date last seen:_____May we update them on your condition?____Yes____No

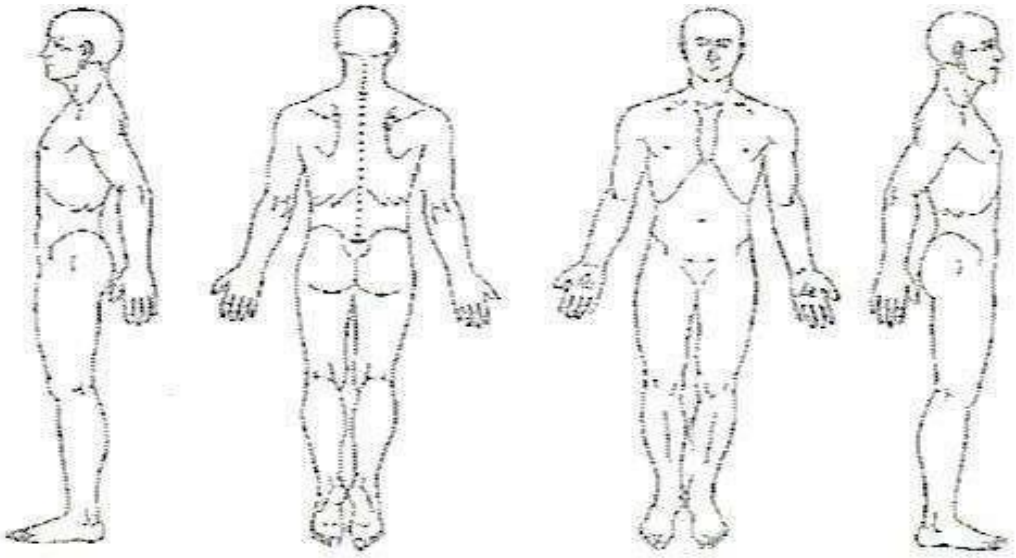
Have you seen a chiropractor before?____Yes____No

Who/When:_____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not Intense 0-1-2-3-4-5-6-7-8-9-10 Unbearable

Please indicate if you have had any of these conditions in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
O	O	Abdominal Pain	O	O	Elbow/upper arm pain	O	O	Liver/Gall Bladder Disorder
O	O	Abnormal Weight gain/loss	O	O	Epilepsy	O	O	Loss of Bladder Control
O	O	Allergies	O	O	Excessive thirst	O	O	Low back pain
O	O	Angina	O	O	Frequent Urination	O	O	Mid back pain
O	O	Ankle/foot pain	O	O	General Fatigue	O	O	Neck pain
O	O	Arthritis	O	O	Hand pain	O	O	Painful Urination
O	O	Asthma	O	O	Headaches	O	O	Prostate Problems
O	O	Bladder Infection	O	O	Heart attack	O	O	Shoulder pain
O	O	Birth Control Pills	O	O	High blood pressure	O	O	Smoking/tobacco Use
O	O	Cancer	O	O	Hip/upper leg pain	O	O	Stroke
O	O	Chest Pains	O	O	HIV/AIDS	O	O	Systematic Lupus
O	O	Chronic Sinusitis	O	O	Hormone Therapy	O	O	Thoracic Outlet Syndrome
O	O	Depression	O	O	Jaw pain	O	O	Tumor
O	O	Dermatitis/Eczema	O	O	Joint swelling/stiffness	O	O	Ulcer
O	O	Dizziness	O	O	Kidney Stones	O	O	Upper back pain
O	O	Drug/Alcohol Use	O	O	Knee/lower leg pain	O	O	Wrist pain

Additional comments you would like the doctor to know: _____

_____

What are your expectations of the chiropractor? _____

_____

What are your goals for treatment?

_____

Patient's signature: _____ **Doctor's signature:** _____

I authorize the below named person/s to have access to my account and discuss my billing information with Fairbanks Chiropractic Clinic.

Name: _____ O I would not like to authorize anyone.

Signature: _____ Print Name: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

OFFICE USE ONLY

Patient acknowledges receipt of *Notice of Privacy Practices*.

Date: _____ Initials: _____ Reason: _____

Fairbanks Chiropractic Clinic: Financial Policy
August 2019

Fairbanks Chiropractic Clinic is happy to work with our patients to provide the best quality of services. This letter is to acquaint you with our financial policy. Please read the following carefully and initial after each section to acknowledge your understanding and agreement to the policy.

Your health insurance may have a deductible as well as a percentage (co-insurance or co-pay fee) for which you, the patient, is responsible. Therefore, it is our responsibility to have all visit fees (co-insurance or co-pay fees) paid for by the patient at the time of his or her appointment.

Initial: _____ Date: _____

Claims are sent out to insurance policies by our billing representative to primary and secondary insurances **as a courtesy** to the patient. Any insurance policies beyond a secondary policy must be billed out by the patient. **Health insurance is an agreement between the patient and the insurance company, not the provider's office.** Since there are no guarantees of payment from the insurance company, you, the patient, are held liable for unpaid balances **after 90 days of the date billed** whether insurance payment is still pending or not. Any balances past 90 days, of the date billed, must be paid in full prior to any additional appointments. In the event that insurance pays after the 90-day period, a check will be issued back to the patient for any account credits at that time.

Initial: _____ Date: _____

Additionally, from time to time, insurance companies may send letters to the patient regarding accident questionnaires. These letters only go to the patient and often the provider's office is unaware they have been sent. It is the patient's responsibility to complete and return these questionnaires to the insurance company in a timely manner, **otherwise claims will be denied.** Claims denied due to lack of communication from the patient are solely the patient's responsibility.

Initial: _____ Date: _____

We encourage you to ask any questions you may have regarding our financial policy so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and establish overall well-being. We have prepared the following checklist in order to help patients determine their responsibility toward payment for chiropractic and/or massage services. Please check the statement that applies to you.

_____ **PRIVATE INSURANCE:** I understand that as a service to me, Fairbanks Chiropractic Clinic will bill my primary and secondary insurance for services rendered. However, I fully understand that it is ultimately my financial responsibility to be liable for all healthcare expenses regardless of insurance coverage. I agree to assume all financial responsibility.

_____**MEDICARE:** I am eligible for Medicare and I understand that it only pays for manipulation of the spine, not for extra-spinal work, muscle work, diagnostic exams, or massage. I also understand that there is a yearly deductible which must be paid by the patient. Medicare will only cover 80% of the allowed fee and I request that Fairbanks Chiropractic Clinic bill my Medicare supplement or secondary insurance, if applicable.

_____**PRIVATE PAY (CASH or CHUSA):** As I have no insurance, or insurance that does not cover chiropractic care, I agree to assume all payment responsibility and keep my account current.
My signature gives Fairbanks Chiropractic Clinic permission to give out pertinent information to my insurance company to facilitate payment for services rendered. **(A scanned copy of this form will be kept in patient's electronic chart)**

Patient Signature (guardian if patient is a minor): _____

Patient Name (printed): _____ Date: _____

No Show/ Late Policy:

If a chiropractic appointment must be cancelled or changed, 24 hours' notice is required so the provider may see others in need. If a new patient or massage appointment must be cancelled or changed, 48 hours' notice is required, as these spaces are less frequently available. In the event that an appointment is on a Monday, we ask that the cancellations be made by Friday at the close of business. In addition, should a patient arrive more than 5 minutes late for his or her scheduled appointment, it will be rescheduled and marked in the patient's chart as a missed appointment.

No shows/missed appointments will result in a charge of $60 for adjustments and $100 for massages and/or new patient appointments.

Initial: _____ Date: _____

Auto Accidents:

In the event that a patient is in an automobile accident, he or she must make an appointment for an initial examination prior to being treated for an injury related to the accident. At this visit, complete claim information must be given to the front desk staff including the company, policy number, claim, and claim adjustor name and contact information**. Additionally, all visits that are to be billed to the auto insurance company must be paid up front due to many auto insurances taking up to one year to pay out claims.** Once the auto insurance company has paid claims, a refund check will be sent to the patient within two weeks.

Initial: _____ Date: _____

Collections:

In the event that an account is past due, reminders will be sent on statements to the last known address for a patient. After three reminders, the patient account will be sent to Cornerstone Collections Agency based out of Anchorage, Alaska. **Once an account has been sent to collections, the patient can no longer be seen at the clinic until the collections has been settled.** Additionally, if an account has been to collections in the past, the first three visits after re-establishing care must be paid for in full.

Initial: _____ Date: _____

Responsibility as a patient:

While we do our best to provide excellent care for our patients, we ask that our patient have the responsibility for:

- Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health.
- Following the treatment plan recommended by those responsible for their care.
- Seeing that their bills are paid as promptly as possible.
- Being considerate of the rights of other patients and clinic personnel.
- Seeking information and in the event that they have questions, asking them.

Patient Signature (guardian if patient is a minor): _____

Patient Name (printed): _____ Date:_____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____