Varney Chiropractic 2019 Update

PERSONAL INFORMATION

PLEASE PRINT

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

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

Birthdate:_____/_____/_____ **Age**_____ **Gender**: □ Male □ Female □ Unspecified **SSN**:_____/_____/_____

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Which email would you like us to use to communicate with you? (check one) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Emergency Contact: (Name, Relationship, Phone#)_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

Primary Insurance Carrier:_____ Phone:_____

Policy#_____ Group #_____ Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____ Employer:_____

Is patient covered by another insurance? □ Yes □ No **Secondary Insurance Carrier**:_____Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Varney Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

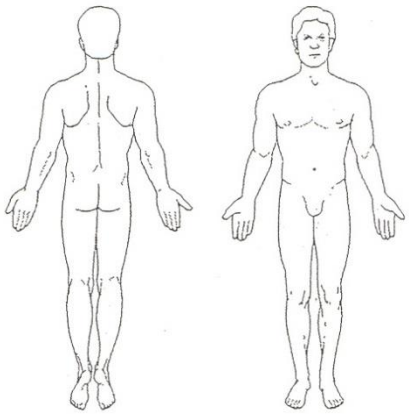
Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? Circle all that apply*: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

On the scale below, please circle the severity of your main complaint right now:

No Pain ***Moderate Pain*** ***Worst Possible Pain***

0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

Area for doctor's notes:

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine since your last visit? □ Yes □ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know <u>allergies you have had to prescription medications</u>. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?:

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓:**

If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

NAME:_____ DATE:_____

VARNEY CHIROPRACTIC

Financial Policy

Patient Name:
Date of Birth:

Thank you for choosing Varney Chiropractic for your wholistic healthcare provider. We are committed to your care and treatment. This financial policy is an important part of your care. Due to increased insurance company demands we ask you to read and agree to the following policy.

*We accept a wide range of insurance plans. However, all policies have different benefits, and we cannot know the specific details of each individual policy. It is **your responsibility** to know your individual policy and to verify all benefits and coverage information prior to having any services rendered. Also, you must notify us of any changes to your insurance plan or policy prior to your visit.*

Co-Payments
***All co-payments must be paid at the time of service** as required by your insurance contract.*
We accept cash, checks, Visa, Mastercard and Discover.

You will be responsible for payment for the following reasons:

1. *You do not have insurance.*
2. *You are insured by a company or a member of a plan with which Varney Chiropractic is not contracted.*
3. *You receive services that are not covered by your policy. For example, some plans do not cover extremity adjusting or manual therapies.*
4. *Your insurance company denies your claim for any reason that is not resolvable.*
5. *You do not provide necessary paperwork, insurance information or other necessary information to file your claim.*

A $25.00 fee will be applied to your account for all returned checks.

Patients with a balance of $100.00 will be required to make a payment on their account and make a payment arrangement before another appointment can be scheduled.

Missed Appointments
*Varney Chiropractic **requires a 24 hour notice to cancel appointments**. A $40.00 fee will be charged for appointments that are not rescheduled within **24 hours** of the appointment time. If you miss three (3) appointments without prior notification to our office, you may be dismissed from our practice.*

Questions about this policy? Call Pat, the Billing Manager at 207-225-5949
I have read and agree to Varney Chiropractic's Financial Policy.

_____ _____ _____

Signature of Patient or Guardian *Print Name* *Date*

Varney Chiropractic
David W. Varney DC
Ruth L. Varney, DC
Warren D. Varney, DC

1071F Auburn Road
Turner, ME 04282
(207)225-5949

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____