First Choice Family chiropractic Rehab & Massage

Patient Information

Today's Date: _____ Birth Date: _____ SS#: _____
First Name: _____ M. I.: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip: _____ Sex: □ M □ F Age: _____ Email: _____
Cell: (___)_____ Home: (___)_____
Emergency Contact: _____ Relationship: _____
Cell: (___)_____ Home: (___)_____ Work: (___)_____
Preferred Reminder Type(Please circle): Phone Call Email Text Message
□ Married □ Single □ Minor □ Widowed □ Divorced
Patient Employer/School: _____ Occupation: _____
Employer/School Address: _____ Phone Number: _____
How did you hear about us? _____

Insurance Information

Who is responsible for this account? _____Relationship to Patient _____

Insurance Co: _____ Member ID: _____

Assignment & Release

I Certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of insurance company) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed for one year from date signed below.

Signature of Patient, Parent, Guardian or Personal Representative: _____

Print name of Patient, Parent, Guardian or Personal Representative: _____

Date: _____ Relationship to patient: _____

Accident Information

Is condition due to an accident? □ Yes □ No Date_____ Type of accident: □Work □Auto □Home □Other
To whom have you made a report of your accident? □Auto Insurance □Employer □Work Comp. □Other
Attorney Name (if applicable): _____

Patient Condition

Reason for Visit: _____

When did your symptoms appear? _____

How often do you have this condition?
□Constant □ Occasional □ Rarely

What activities worsen your pain?
□ Bending □ Sleeping □ Lifting □ Coughing □ Standing □ Arising From a Chair □ Exercising □ Other

What activities relieve your pain?
□ Pain Meds □ Stretching □ Sitting □ Walking □ Standing □ Heat/Cold □ Exercising □ Other

Medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Vitamins/Minerals: _____
_____

Surgical History:
Type: _____ **Where** _____ **When** _____
Type: _____ **Where** _____ **When** _____
Type: _____ **Where** _____ **When** _____

Hospitalizations:
Cause _____ **When** _____ **Remaining Problems** _____
Cause _____ **When** _____ **Remaining Problems** _____
Cause _____ **When** _____ **Remaining Problems** _____

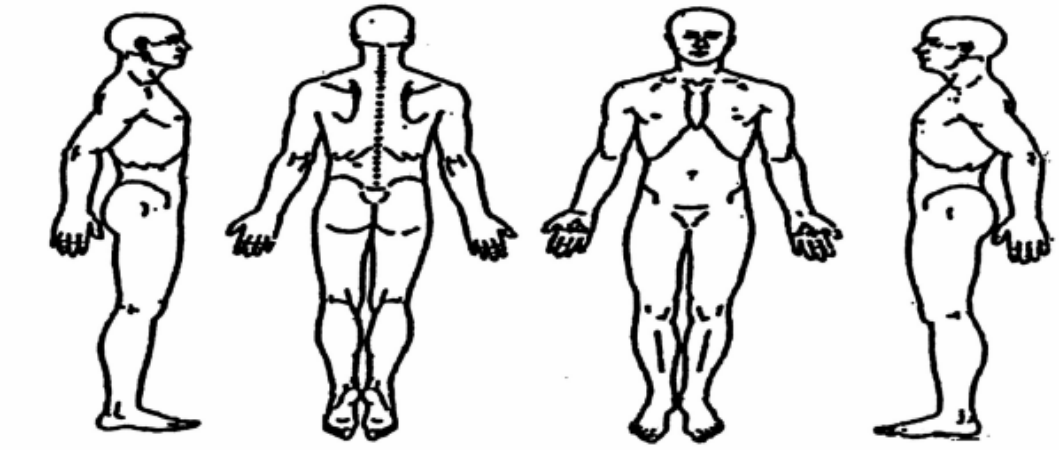
Broken Bones: _____ **When** _____ **Surgeries** _____
_____ **When** _____ **Surgeries** _____
_____ **When** _____ **Surgeries** _____

Previous tests for THIS condition:
□ **X Ray** **Date:** _____ **Ordered By:** _____
□ **MRI** **Date:** _____ **Ordered By:** _____
□ **Other** **Date:** _____ **Ordered By:** _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. **Is today's problem caused by:** □Auto Accident □Workman's Compensation □ Other
2. **Indicate on the drawings below where you have pain/symptoms**



3. **How often do you experience your symptoms?**
   - □ Constantly (76-100% of the time)
   - □ Frequently (51-75% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Intermittently (Intermittently (1-25% of the time)

4. **How would you describe the type of pain?**
   - □ Sharp
   - □ Dull
   - □ Diffuse
   - □ Achy
   - □ Burning
   - □ Shooting
   - □ Stiff
   - □ Numb
   - □ Tingly
   - □ Sharp with motion
   - □ Shooting with motion
   - □ Stabbing with motion
   - □ Electric like with motion

   Other: _____

5. **How are your symptoms changing with time?**
   □ Getting worse □ Staying the same □ Getting Better

6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

   0 1 2 3 4 5 6 7 8 9 10 (please circle)

7. **How much has the problem interfered with your work?**
   □Not at all □A little bit □ Moderately □ Quite a bit □ Extremely

8. **How much has the problem interfered with your social activities?**
   □Not at all □A little bit □ Moderately □ Quite a bit □ Extremely

9. **Who else have you seen for your problem?**
   - □ Chiropractor
   - □ ER Physician
   - □ Massage Therapist
   - □ Neurologist
   - □ Orthopedist
   - □ Physical Therapist
   - □ Primary Care Physician
   - □ Other: _____
   - □ No one

10. **How long have you had this problem?** _____

11. **How do you think your problem began?**

    _____

12. **Do you consider this problem to be severe?**
    □ Yes □ Yes, at times □ No
13. **What aggravates your problem?**
    _____
14. **What concerns you the most about your problem; what does it prevent you from doing?**
    _____
15. **What is your: Height _____ Weight _____ Date of Birth _____**
16. **For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Drug/Alcohol Dependence
□	□	Low Back Pain	□	□	Angina	□	□	Allergies
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Depression
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Systemic Lupus
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Epilepsy
□	□	Hand Pain	□	□	Painful Urination	□	□	Dermatitis/Eczema/Rash
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	HIV/AIDS
□	□	Upper Leg Pain	□	□	Prostate Problems			FOR FEMALES ONLY
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss	□	□	Birth Control Pills
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	Hormone Replacement
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Pregnancy
□	□	Joint Pain/Stiffness	□	□	Ulcer			
□	□	Arthritis	□	□	Hepatitis			
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other _____						

17. **What is your occupation: _____**
18. **What activities do you do at work?**

□ Sit	□ Most of the day	□ Half of the day	□ A little of the day
□ Stand	□ Most of the day	□ Half of the day	□ A little of the day
□ Computer work	□ Most of the day	□ Half of the day	□ A little of the day
□ On the phone	□ Most of the day	□ Half of the day	□ A little of the day

19. **Have you ever been hospitalized?** □ Yes □ No
    If yes, why? _____
20. **Have you had significant past trauma?** □ Yes □ No
21. **Anything else pertinent to your visit today?**
    _____

Patient Signature: _____ Date: _____

First Choice Family Chiropractic Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, MasterCard or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (WORKERS COMPENSATION)

If you are injured on the job, your care should be paid for under your employer's workers compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to PI patients:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim until after your care is completed. After settlement, your balance will be due. If First Choice Family Chiropractic has to resort to debt collection I understand that I am responsible for any fees used to obtain my debt. Once the claim is settled or if you suspend or terminate care, any fees for services are due

immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services and fees we provide are NOT COVERED. These services include, but are not limited to, X-Rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

☐ You are required to pay a $_____ co-pay at the time of service.

☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

☐ Benefits are available for up to _____ visits per year. A $_____co-pay is due at the time of service.

☐ All outstanding deductible should be paid in full at time of service unless a payment plan has been arranged. All payment plans should be completed within a 6 month time frame.

MISSED APPOINTMENTS

A $30.00 missed appointment fee will be added to your bill if appointments are not cancelled with 24 hours notice of the appointment.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a “flex plan”. We will be happy to provide you with a statement of your charges for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible, occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office may come to you instead of our office. If you should receive any unexpected checks in the mail, please contact us to see if it represents payment of your bill here

I ALSO UNDERSTAND THAT IF MY INSURANCE DOES NOT RESPOND WITHIN 60 DAYS, OR IF I SUSPEND OR TERMINATE MY SCHEDULE OF CARE AS PRESCRIBED BY THE DOCTORS AT FIRST CHOICE FAMILY CHIROPRACTIC THAT FEES WILL BE DUE AND PAYABLE IMMEDIATELY ALONG WITH ANY INTEREST FEE, COLLECTION FEE, OR COURT COST USED TO OBTAIN MY DEBT. I UNDERSTAND THAT FIRST CHOICE FAMILY CHIROPRACTIC WILL NOT ALLOW A DEBT GREATER THATN $100. IN THE EVENT I NEED TO MAKE A PAYMENT PLAN I ALSO UNDERSTAND THAT I MUST FIRST DECREASE MY BALANCE TO $100 BEFORE SAID PAYMENT PLAN CAN BE ARRANGED UNLESS I HAVE MADE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. ALL AGREEMENTS MUST BE WRITTEN AND SIGNED BY BOTH PARTIES. ALL PERSONAL INJURY CASES WILL HAVE A 6 MONTH GRACE PERIOD FROM THE DATE OF RELEASE. IF NO PAYMENT HAS BEEN MADE ON MY BEHALF I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE END OF MY GRACE PERIOD ALONG WITH ANY FEES STATED ABOVE USED TO COLLECT THE DEBT.

_____

Patient’s signature (or guardian if patient is a minor) **Date**

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INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (We) hereby consent to the performance of examination and treatment on me or on _____ by the licensed doctors of chiropractic, medical doctors; and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to: fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness

First Choice Family chiropractic Rehab & Massage

PREGNANCY WAIVER

I hereby acknowledge that Dr. Jeff Stratford and/or Dr. April Stratford of the First Choice Family Chiropractic Center has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own volition that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____
Printed Name of Patient

_____
Signature of Patient/Authorized Representative of Patient

_____
Date

_____
Witness