LOVELAND
FAMILY CHIROPRACTIC

Chiropractic Case History/Patient Information

Date:_____ Patient #_____

Name:_____ Social Security #_____ Home Phone:_____

Address:_____ City:_____State:_____Zip:_____

E-mail address:_____ Fax #_____Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____Occupation:_____Employer:_____

Number of children:_____Names and ages of children:_____

Emergency Contact Name:_____Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have the permission to update your medical doctor regarding your care at this office? Yes_____ No_____

Please check any and all insurance coverage that may be applicable:

_____Major Medical _____Worker's compensation _____Medicaid _____Medicare

_____Auto Accident _____Medical Savings Account & Flex Plans _____Other

Name of Primary Insurance Company:_____

Primary Insurance Holder's Name & Birth Date:_____

Name of Secondary Insurance Company (if any):_____

Secondary Insurance Holder's Name & Birth Date:_____

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers or payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow the chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Heath Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) may have my permission to receive my personal health information:_____

Patient Signature/Guardian's Signature Authorizing Care: _____Date:_____

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Child Intake Form

Present Health Challenge(s)

What health challenge(s) is your child here for? When did it begin?

_____

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

_____

What was the outcome of prior treatment/recommendations?

_____

_____

Health History

Symptoms: Please check any current or past problems your child has on the list below:

___Anemia
___Arthritis
___ADHD
___Allergies
___Anxiety
___Arm/Elbow Pain
___Asthma
___Autism
___Backaches
___Behavioral Issues
___Bed Wetting
___Blood disorders
___Broken Bones:_____
___Chest Pain
___Chronic Earaches
___Colic
___Concussions
___Constipation
___Convulsions
___Cough/Wheeze
___Diabetes
___Diarrhea
___Digestive Problems
___Dizziness
___Eczema
___Fainting
___Fever/Chills
___Frequent Colds
___Growing Pains
___Headaches
___Heart Condition
___Hernias
___Hyperactivity
___Hypertension
___Joint Pain
___Insomnia
___Itchy Eyes
___Knee/Foot Pain
___Leg/Hip Pain
___Muscle Pain
___Neck Pain
___Nightmares
___Poor Appetite
___Poor Memory
___Rashes
___Reflux/Spitting up
___Runny Nose
___Scoliosis
___Sinus Trouble
___Sprains/Strains
___Stomach Aches
___Unusual Moles
___Other:_____

Name of Pediatrician: _____Date of Last Visit:_____

Current Medications & Vitamins: _____

Past Traumas (falls, sports injuries, accidents, etc):_____

_____

Past Surgeries: _____

Prenatal History

Location of Birth: ___Home ___Birthing Center ___Hospital

Complications during pregnancy: Y - N List: _____

Medications during pregnancy/delivery: _____

Cigarette / Alcohol use during pregnancy: Y – N

Birth Interventions: ___Forceps ___Vacuum ___Caesarian

Complications during delivery: Y – N List: _____

Birth Weight: _____ Birth Length: _____

Feeding History

Breast Fed: Y – N How long?_____Formula Fed: Y – N How long?_____Type: _____

Introduced to cereal at ____ months. Solids at ____ months. Cow's milk at ____ months.

Food / Juice allergies or intolerances: Y – N List: _____

Developmental History

Sleep (Hours per night) _____ Problems Sleeping: _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y - N

If yes, please explain: _____

Has your child been vaccinated? Y - N

Adverse reactions to any vaccine? _____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____ , as the parent/guardian of this child, _____ , hereby grant permission for my child to receive examination and chiropractic care as deemed necessary.

Signature of Parent or Guardian: _____ Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Printed Name: _____ Date: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20___

Patient's Signature: _____

If patient is a minor or under a guardianship order as defined by State Law:

Signature of Parent/Guardian (circle one) _____

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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, Discover, Master Card, 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 pa 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 any 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 my then submit the bill to your insurance carrier for reimbursement.

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 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 we provide are NON-COVERED. These services include but are not limited to, examinations, therapies, orthotics, supports, kinesiotape, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's 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 the PI patient:

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.
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 for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

SECONDARY INSURANCE

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

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 check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Loveland Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Loveland Family Chiropractic and my insurance company. I request that Loveland Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. 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 doctor at Loveland Family Chiropractic that fees will be due and payable immediately.

Patient's Signature (or guardian if patient is a minor)_____ Date: _____

Witness: _____Date:_____