Chiropractic Case History/Patient Information

Date:_____

PERSONAL INFORMATION

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____ Birth date: _____

Marital: M S W D Occupation:_____

Employer name, address, phone #: _____

Spouse/other:_____Occupation:_____Employer:_____

Name of person(s) we can discuss your care/account with (name, address, phone #)? _____

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

# of children?_____ Names and Ages of Children:_____

Who may we thank for your referral to our office? _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? YES NO If yes: Physicians name, address, phone #: _____

_____

HISTORY OF PRESENT CONDITION(S)

1) Chief Complaint(s):_____

2) Date symptoms appeared or accident happened:_____

3) Is this due to: Auto Work Other _____

4) Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____

_____

5) Days lost from work:_____ Date of last physical examination:_____

6) What does this prevent you from doing or enjoying?_____

7) Has it become worse recently? Yes No If yes, when & how? _____

_____

8) How frequent is the condition? Constant Daily Intermittent Night Only

9) How long does it last? All Day Few Hours Minutes

10) Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

11) What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

12) Is there anything you have done that relieves the problem? If so please describe: _____

_____

What have you tried that has **NOT** relieved the problem? _____

_____

13) Are there any other conditions or symptoms that may be related to your major symptom? Yes No

If yes, describe: _____

14) Have you ever been knocked unconscious or had the wind knocked out of you? Yes No

If so please explain: _____

15) Were you in any High school sports, if so list and list any injuries you sustained? _____

_____

Name:_____ **Date:**_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive bleeding
__Osteoarthritis
__Epilepsy
__Pace Maker
__Ruptures
__Coughing Blood
__High/low blood pressure
__Eating Disorder
__Alcoholism
__Drug Addiction
__Strokes
__Cancer
__Ulcers
__Depression
__HIV Positive
__Gall bladder

Have you had any major illnesses? _____

Injuries or falls? _____

Auto or work accidents? _____

Surgeries? Women, please include information about childbirth (include dates):

_____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have allergies to any medications? Yes No

If yes, describe:_____

Do you have allergies of any kind? Yes No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No If so, how much per week?_____
Do you use any tobacco products? Yes No If so, packs/dips per day: _____
Do you take vitamin supplements? Yes No If so, please list:_____
Do you consume caffeine? Yes No If so, how much per day:_____
Do you exercise? Yes No If so, what is the frequency & type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at work) do you spend:
Lifting_____ Sitting_____ Bending_____ Working at a computer_____

FAMILY HISTORY

Father: Living Current age: _____ Deceased Cause of death & age: _____

Mother: Living Current age: _____ Deceased Cause of death & age:_____

Are you adopted (sometimes as an adopted child, little is known of birth parents or family). Yes No

Do you have any family members who suffer from the same condition you do?
If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____
Cancer____
Asthma____
Kidney Disease____
Liver Disease ____
Mental Illness____
Heart Disease ____
Lung Disease____

INSURANCE (Please present the front desk with a copy of your current insurance card(s))

Please circle any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

Primary Insurance: _____

Secondary Insurance: _____

Do you have a Medical Savings Account & Flex Plans? YES NO

INSURANCE AUTHORIZATION AND 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 and 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. **(Please sign even if you do NOT have any insurance coverage)**

Signature:_____Date:_____

INFORMED CONSENT/TREATMENT AUTHORIZATION

I, the undersigned, have been informed by the participating treating Doctor of Chiropractic (D.C.) listed below, that he is a licensed chiropractor, and having been informed by such Doctor as to the benefits and potential risks of chiropractic treatment, hereby consent to such treatment including the taking of my pictures.

I hereby agree to hold Dr. Benjamin Heun D.C. and their affiliates, all associated sanctioned events and/or endorsement levels in **Back In Action Chiropractic LLC**; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands, or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Wavier and Authorization to Treat to be binding and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Signature: _____Date: _____

PATIENT HEALTH INFORMATION CONSENT FORM (HIPPA)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Date

Back In Action Chiropractic LLC

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, Dr. Benjamin Heun D.C. will suggest the chiropractic care he thinks you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We require 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 cash, checks, and all major credit cards. You may also pay the full amount due each day thereby qualifying for our time of service discount. No insurance will be filed when given the time of service discount.

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 some 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 and it is ultimately your responsibility to call and find out what your benefits are. 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 at the time of service or once we receive the explanation of benefits from your insurance. No treatment plan will be submitted to your insurance after your visit limit has been met. Payment may be made at the end of the week if you sign a credit guarantee form.

"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, and give you permission to seek Chiropractic care. If your employer does not provide us with this information before you leave our office on your first visit, any fees and services are due immediately. Fees are also due immediately by you if you terminate your schedule of care before the doctor has released you. You must have a signed credit guarantee on file in order to have us hold your bill and wait for insurance payment. If your insurance carrier takes longer than 45 days to pay on claims you will be billed for these services and any monies we eventually receive from insurance will be refunded to you.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, a copy of the accident report, any other party's insurance information that was involved, and tell us if you have retained an attorney. We also need the claim number, adjustors name and address, and the medical payments amount that your insurance will pay. There are three options available to the PI patient:

1. **Pay for your care at the time of service and we will submit reports whenever necessary.**
2. **We will bill (accept assignment) from the Med Pay portion of your auto insurance, with a credit guarantee signed and on file. If your insurance carrier takes longer than 45 days to pay claims you will be billed for these charges and any monies we may eventually receive from insurance will be refunded to you.**
3. **We will bill your health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.**

You are ultimately responsible for all charges regardless of insurance coverage, and if you cancel/terminate your care for any reason before the doctor has released you all charges will be due immediately by you.

MEDICARE

We accept assignment from Medicare. This means that Medicare will pay us for all covered services rendered and Medicare will send reimbursement checks to Back In Action Chiropractic LLC. Medicare reimburses for only manual manipulation of the spine. They pay 80% of the allowable fee once the deductible has been met. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, extremity adjustment, 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. Please inform us if you have secondary insurance and we will assist you in filing.

MEDICAID (TITLE 19)

Exams and x-rays are required by Medicaid and are routine office procedures for all patients. Medicaid will not pay for these services and are the responsibility of the patient. Payment for these services and your co-pay are due at the time of service. Medicaid only reimburse for manual manipulation of the spine, all other services are NON-COVERED and are the patient's responsibility.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan', or health savings account (HSA). We will be happy to provide you with a statement of your charges for reimbursement.

Please be advised: We will charge **$30.00** for all returned checks for whatever reason. After we receive 2 returned checks you will no longer be allowed to write checks on the account. Another form of payment must be provided.

CARE CREDIT: We now offer medical financing options with LOW monthly payments to help you receive the care you need and want while being able to afford it. If you are interested let us know!

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 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 **Back In Action Chiropractic LLC**. I understand that my insurance is an arrangement between myself and my insurance company, NOT between **Back In Action Chiropractic LLC** and my insurance company. I give Dr. Benjamin Heun D.C. and staff permission to release all information necessary to communicate with other physicians, health care providers, and payers to help receive insurance benefits and to have them assigned and payable to **Back In Action Chiropractic LLC**. I also understand that if my insurance does not respond within 45 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at **Back In Action Chiropractic LLC** that fees will be due and payable immediately. I understand that I am ultimately responsible for all charges regardless of insurance coverage, and that is my responsibility to know my insurance benefits. Should **Back In Action Chiropractic LLC** have to take legal action against me in order to collect my bill I will be held responsible for all attorneys' fees, collections fees, court fees, and another other fees resulting from these actions. A $25.00 service charge will also be added to my account. I also understand that if my account is more than 45 days past due I will be charged a late fee of $5.00 per month.

PRACTICE MEMBER POLICIES FOR Back In Action Chiropractic LLC

OUR COMMITMENT: We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time.

FINANCIAL POLICY:

- It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers.
- All payments are expected at the time of service. Practice member balances may not exceed $100 at any time, unless a credit guarantee has been signed to pay this at the end of each week.

INSURANCE POLICY: It is the patient's responsibility to know whether or not Dr. Benjamin Heun D.C. and this clinic are participating providers with your insurance plan.

- If we are in network with your insurance company we will file your insurance for you but we require a credit guarantee on file. You will be responsible for all deductibles and co-pays at the time of service and we will wait for remaining payment from the insurance company. However, upon receiving the insurance's explanation of benefits if there is a remaining balance due after they have paid on your claim it will be charged your credit card.
- You are considered a cash patient until our office "verifies" your coverage to determine the extent of benefits under your policy. Benefits quoted to us are not a guarantee of payment and should your claims be denied you are responsible for payment in full at that time.
- Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
- This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with any insurance company over the amount of reimbursement. You are ultimately responsible for all charges regardless of insurance coverage, which includes but is not limited to all non-covered services for any reason.
- If we are out of network with your insurance company you will be responsible for all charges at the time of service. We will file the claims for you at no charge, and any reimbursement will be sent directly to you by your insurance company. If your insurance company accidentally sends us the reimbursement check it will be credited to your account.
- Since we do not own your insurance policy, and occasionally, we experience difficulty in collecting from the insurance carrier, we may ask for you active assistance in rectifying this situation. If you are unwilling to comply with this request you will be responsible for the balance in full at that time.

OUR COMMITMENT: The goal of this office is to provide you with the finest quality chiropractic care available. If you have any questions with regard to your healthcare, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

PERSONAL CREDIT CARD INFORMATION: This information is to be only used by **Back In Action Chiropractic LLC** and only in the event of the reasons stated above.

Patient's Name_____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Account Number: _____-_____-_____-_____ Exp. Date: _____

VIN (three digit #)_____ Type of card: MC VISA AMEX DC

SIGNATURE:_____ DATE: _____