

Natural Way Chiropractic

Confidential patient information

Date _____

Name _____ Sex _____ Marital Status _____ DOB _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Home phone _____

Cell Phone _____

E-mail Address _____

Social Sec# _____

Occupation _____

Company Name _____

Location _____

Phone# _____

Guardian/Spouses name _____

Guardian/spouses DOB _____

Guardian/spouses SS# _____

Guardian/spouses employer _____

Location _____

phone# _____

Name of nearest relative (not your spouse): _____ Phone _____

Who referred you to, or how did you hear about, our office? _____

Were you referred to a certain doctor in this office? _____

Is your visit due to an accident? (circle) Yes No (If yes, please see receptionist for an injury report.)

Your present complaint _____

Briefly describe your symptoms _____

List other doctor(s) seen for this condition _____

Personal Medical history (if any of the following are relevant to your medical history, please circle all that apply.)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Venereal Disease |

Have you ever had chiropractic care? (circle) Yes No Date of last adjustment _____

Have you ever had massage therapy? (circle) Yes No Date of last massage _____

Describe any operations you've had and the dates: _____

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

Describe condition _____ Date of last physical exam _____

Are you now taking any medication? (circle) Yes No What Kind? _____

Are you pregnant? (circle) Yes No Date of last menstrual period _____

Do you have insurance? (circle) Yes No Company _____

Primary Care Physician _____ Location _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Natural Way Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Natural Way Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____

Personal Injury History Form

Instructions: Please carefully consider and answer each question as completely as possible.

Name: _____ Today's Date: (____/____/____) Date of Accident:(____/____/____)

If this was an auto accident, were you the: Driver Passenger Pedestrian

If auto collision, were you struck from: Behind Right Left Front Auto was parked

other _____

Did your car strike the other(s) involved? Yes No. Did the other car strike yours? Yes No.

Were traffic tickets issued? Yes No. If "yes," to whom: You the other driver the driver of your car.

Did any part of your body strike any part of the car? Yes No. If "yes," please explain: _____

Did you have a safety belt on? Yes No. Shoulder strap? Yes No.

Does your car have a headrest? Yes No. Height or position? Shoulder Neck Head Above.

Did you lose consciousness? Yes No. If "yes," please explain: _____

Were you stunned? Yes No. If "yes," how long? _____

Did you feel or hear a popping, tearing, or a ripping noise in your neck or back? Yes No. If "yes," please explain: _____

Did you feel any pain? Yes No. If "yes," where? _____

How long after the accident did you feel pain? _____

Did you notice any bruising? Yes No. If "yes," where? _____

Did you require post-accident care or hospitalization? Yes No. If "yes," where? _____

Were you examined by a healthcare professional? If "yes," by whom? _____

Were you x-rayed? Yes No. Was any treatment given? (medication, supports, braces, or recommendations):

What is your occupation? _____ What duties are required of you on the job? _____

Have you missed work as a result of this accident? Yes No. If "yes," how many days? _____

Insurance Companies

Your Insurance Company _____ Ins. Adjustor Name: _____

Address _____ City _____ State _____ Phone _____

Insurance of responsible party? _____ Ins. Adjustor Name: _____

Address _____ City _____ State _____ Phone _____

Your Attorney

Name of Firm: _____ Attorney Name: _____

Address _____ City _____ State _____ Phone _____

Instructions: Please check symptoms you have experienced since the accident.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Skull or Head Pain | <input type="checkbox"/> Low Back Stiffness | <input type="checkbox"/> Loss of color, pale | <input type="checkbox"/> Excessive Perspiration |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Perspiration |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Buttock Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Leg Pain (Rt/Lt) | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Leg Numbness | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Shoulder Stiffness | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Swelling in _____ |
| <input type="checkbox"/> Arm Pain (Rt/Lt) | <input type="checkbox"/> Numbness in Feet/Toes | <input type="checkbox"/> Difficulty Focusing | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Arm Numbness | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Pain Behind the Eyes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Loss of Circulation | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Excessive Sleep |
| <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Tension | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Upper Back Stiffness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tremors | <input type="checkbox"/> Rib Pain |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Mental Dullness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Mid Back Stiffness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Nausea | <input type="checkbox"/> Difficulty Rising |
| <input type="checkbox"/> Pain doing occupation | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fatigue |

YOUR SYMPTOMS

NECK

- | | | | |
|---|--|--|---|
| The PAIN is:
___ Constant
___ Intermittent
___ Occasional | The SEVERITY is:
___ Mild
___ Moderate
___ Severe
Other _____ | the QUALITY is:
___ Dull
___ Sharp
___ Stabbing
Other _____ | The PAIN is greater:
___ on the left side
___ on the right side
___ equal on both sides |
|---|--|--|---|

MIDBACK

- | | | | |
|---|--|--|---|
| The PAIN is:
___ Constant
___ Intermittent
___ Occasional | The SEVERITY is:
___ Mild
___ Moderate
___ Severe
Other _____ | the QUALITY is:
___ Dull
___ Sharp
___ Stabbing
Other _____ | The PAIN is greater:
___ on the left side
___ on the right side
___ equal on both sides |
|---|--|--|---|

LOWBACK

- | | | | |
|---|--|--|---|
| The PAIN is:
___ Constant
___ Intermittent
___ Occasional | The SEVERITY is:
___ Mild
___ Moderate
___ Severe
Other _____ | the QUALITY is:
___ Dull
___ Sharp
___ Stabbing
Other _____ | The PAIN is greater:
___ on the left side
___ on the right side
___ equal on both sides |
|---|--|--|---|

OTHER

- Please explain the location of the pain (i.e. right forearm, left calf) _____
- | | | | |
|---|---|---|---|
| The PAIN is:
___ Constant
___ Intermittent
___ Occasional | The SEVERITY is:
___ Mild
___ Moderate
___ Severe | the QUALITY is:
___ Dull
___ Sharp
___ Stabbing | The PAIN is greater:
___ on the left side
___ on the right side
___ equal on both sides |
|---|---|---|---|

WHAT CAUSES YOU DIFFICULTY:

Please check as many as necessary.

 STANDING **SITTING** **LYING DOWN** **OTHER**_____

WALKING: **RIDING: (in auto)** **BENDING:** **TWIST/TURN:** **LIFTING:** **RISE TO WALK**

 Minimal Minimal Minimal Minimal Light
 Moderate Moderate Moderate Moderate Medium **COUGH or SNEEZE**
 Extended Extended Extended Extended Heavy
 Repetitive Repetitive

DOES THE PAIN RADIATE into your...

Please check as many as necessary.

SHOULDER(S) **ARM(S)** **HIP(S)** **LEG(S)** **IS WORSE:** **INTERFERES with:**

 left left left left in the a.m. work
 right right right right in the p.m. sleep
 both both both both following: other _____
 other: Pain radiates into my _____
 routine activity _____
 moderate activity _____

OFFICIAL USE ONLY

Date of Accident: _____ Time: _____ (am/pm) Weather: _____ Road Conditions _____

Street(s): _____

Street(s): _____

Patient Headed (N S E W)

Patient Speed: _____ Mph

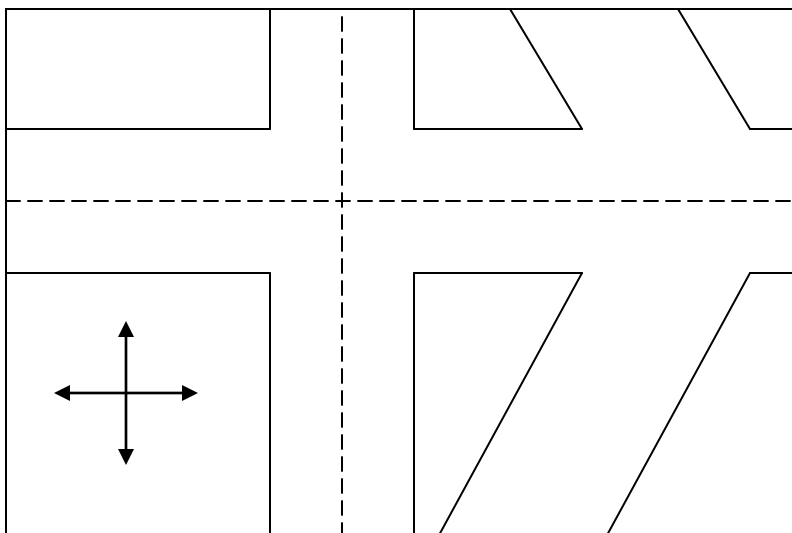
Patient Car Type: _____

Patient Car Hit: _____

Other(s) Headed (N S E W)

Other(s) Speed: _____ Mph

Other(s) Car Type: _____



IMPACT

Body: (Straight / Bent / Twisted) (Left / Right)

Head: (Neutral / Up / Down) (RT / LT)

Braking: (On / Off)

Patient Awareness: (None / Partial / Very)

Miscellaneous: _____

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

Complimentary Consultation

Natural Way Chiropractic will conduct a special “no charge” consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient’s health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services

Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker’s Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance

Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take

responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Natural Way Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Natural Way Chiropractic will be credited to your account upon receipt.

Appointments

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Our office has a \$25.00 no show/late cancellation charge if we fail to receive 24 hours notice. Please call our office as soon as possible if you are not going to make your scheduled appointment.

Identification Policy

Natural Way Chiropractic requires a copy of photo identification (ex: drivers license, passport, student ID) be on file in order to receive care. Also, we require an electronic photo be taken and placed into your medical chart for verification purposes.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Natural Way Chiropractic clinic policies and agree to honor them:

Patient’s Signature

Date



NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the service provided to you for the following reasons:

That the particular service is not reasonable and necessary under my insurance companies standards.

For this reason, please read and sign the following statement:

“I have been informed by my physician that he believes that, my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services.

Patient Signature

Date

ASSUMPTION OF FINANCIAL RESPONSIBILITY

****Explanation of benefits disclaimer****

I, the undersigned patient, completely understand that Natural Way Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Natural Way Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Natural Way Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Natural Way Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a “signature on file” to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above “Benefits Disclaimer” and my financial responsibilities to any services rendered by this clinic.

I understand that Natural Way Chiropractic, PS may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Patient Signature

Date

NATURAL WAY CHIROPRACTIC

"Healthcare for your lifestyle"



We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Natural Way Chiropractic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

You may refuse to sign this acknowledgement

By my signature below I acknowledgement receipt of the Notice of Privacy Practices

Patient or legally authorized individual signature	Date	Time
--	------	------

Printed name if signed on behalf of patient	Relationship
---	--------------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Additional Disclosure Authority

In addition to the allowable disclosures describe in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Any member of my immediate family: Yes___ No___.

Spouse Only: Yes___ No___.

Other: (Please Specify)_____ Yes___ No___.

My Designated Primary Care Provider: Yes___ No___ *Re-evaluation findings only.

Signature:_____.