WELCOME

1 ABOUT YOU

Today's Date: _____ File #: _____

Patient Name: _____

Prefer to be Called: _____ □ Male □ Female

DOB: _____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext.: _____

Other Phone #'s: _____

Email Address: _____

Referred by: _____

Employer: _____ How long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name: _____

Have children? □ Yes □ No If so, how many? _____

2 INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

Social Security #: _____

Driver's License #: _____

Primary Phone #: _____

Secondary Phone #: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4 IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Primary Phone #: _____

Secondary Phone #: _____

Who is your Medical Doctor? _____

MD's Phone #: _____

CONTINUED ON BACK

5 REASON FOR VISIT

Reason for today's visit: □ Emergency □ New injury □ Old injury □ Chronic pain □ Wellness

Are you in pain? □ Yes □ No Rate your pain on the scale: discomfort 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 intense

Did your injury occur during: □ Work □ Sports/play □ Auto accident □ Routine/household activity

When did your condition/accident occur? _____ Where? _____

Please explain what happened: _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Is your condition interfering with your: □ Work □ Sleep or □ Daily routine? If so, how? _____

_____

Has this or something similar happened in the past?

□ Yes □ No Explain: _____

_____

Using the body charts, please circle all affected areas.

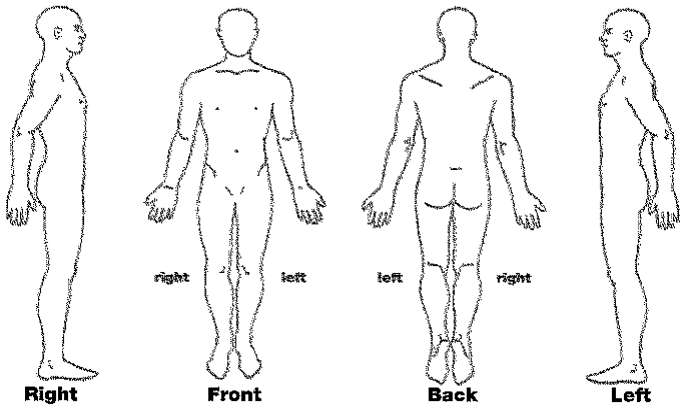
Have you been treated by a Medical Physician for this condition? □ Yes □ No If so, where? _____

_____

Have you ever seen a chiropractor? □ Yes □ No

Clinic/doctor's name: _____

Clinic phone #: _____



6 HEALTH HISTORY

Are you taking any of the following medications? □ Nerve pills □ Painkillers (including Aspirin) □ Muscle relaxers □ Insulin □ Blood thinners □ Tranquilizers □ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart attack/stroke	Y N Heart surg./pacemaker	Y N Heart murmur	Y N Congenital heart defect	Y N Mitral valve prolapse
Y N Artificial valves	Y N Alcohol/drug abuse	Y N Venereal disease	Y N Hepatitis	Y N HIV/AIDS/ARC
Y N Shingles	Y N Cancer	Y N Frequent neck pain	Y N Glaucoma	Y N Anemia/Diabetes
Y N High/low blood pressure	Y N Psychiatric problems	Y N Rheumatic Fever	Y N Severe/frequent headaches	Y N Kidney problems
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus problems	Y N Emphysema/Asthma	Y N Tuberculosis
Y N Difficulty breathing	Y N Chemotherapy	Y N Lower back problems	Y N Artificial bones/joints	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family health history: _____

Do you take supplements or vitamins? □ Yes □ No Do you exercise? □ Yes □ No If so, how often? _____

Do you smoke? □ Yes □ No How much? _____ For how long? _____

Are you wearing: □ Shoe lifts? □ Inner soles? □ Arch supports? Are you dieting? □ Yes □ No How long? _____

For women: Are you taking birth control? □ Yes □ No

Are you nursing? □ Yes □ No Are you pregnant? □ Yes □ No If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

DATE: ___/___/_____ PATIENT NAME _____ DR. JARROD B. LIPPY, D.C.

YOUR SYMPTOMS

What is your major symptom? _____

How did it originally occur? _____

Has it become worse recently? Yes _____ No _____ Same _____ Better _____ Gradually worse _____

If yes, when and how? _____

How frequent is it? Constant _____ Daily _____ Intermittent_____ Night Only _____

How long does it last? All Day _____ Few Hours _____ Minutes _____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____ Burning _____ Stabbing _____

Is there anything you can do to relieve the problem? Yes _____ No _____
If yes, please describe: _____
If no, please list what you have tried: _____

What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____ Twisting _____
Other? _____

Dr. Jarrod Lippy's Remarks:

_____
_____
_____
_____
_____
_____

_____ _____
(Doctors Signature) (Today's Date)

_____ _____
(Patient's Signature) (Today's Date)

DATE: _____ PATIENT: _____

AUTHORIZATIONS

Notice of Privacy Practices

We are required by law to maintain the privacy of your protective health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. Our notice is effective as of 12/2014, and we are required to abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of our notice. Please sign below indicating that you are aware of being able to receive a copy of our notice when requested. The signature also indicates that you are aware of where to find it in the office, in case you'd like to review the notice (on the table in the waiting area).

PATIENT SIGNATURE_____

Patient Consent

Consent for Treatment: I voluntarily consent to rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending Doctor(s) of Chiropractic and it is the responsibility of the staff to carry out the instructions of such Doctor(s) of Chiropractic.

Assignment of Benefits: I hereby assign payment directly to Advanced Correction Chiropractic and Physical Therapy accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed regular charges. I understand that I am financially responsible for charges not cover by this agreement or for any and all charges that the insurance carrier declines to pay. In the event that any part of the medical bill is unpaid when due, I agree to pay all costs and expenses of collection, including but not limited to staff time, court costs, attorneys fees and all other related expenses.

PATIENT SIGNATURE_____

Medicare and Medicaid Consent to Release Information

I certify that the information given by me applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct and I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claims.

PATIENT SIGNATURE_____

Financial Policy

Patients without Insurance are requested that 100% of the visit is paid at the time of the visit. For Group and/or Individual Insurance, when possible, we will call to verify your insurance. However, the benefits quoted to us by your insurance company ARE NOT a guarantee of payment. Payment will be due by you at the time of service for non-covered services, deductibles and/or Co-Pays. If you are injured on the job, your care should be paid for under 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, the case is not settled within three months or if you suspend/terminate the case, any fees and services are due immediately. In case of an auto accident, the insurance is to be informed immediately, especially if you are using representation by an attorney. Although the bill is ultimately your responsibility, we will wait for settlement for your claim up to six months. Once the claim is settled, or if you suspend care, any fees or service are due immediately. Medicare ONLY covers for manual manipulations of the spine by 80% of the allowed amount, the other 20%, non-covered services and the deductible is solely your responsibility and due immediately. Please, inform us of any secondary insurance. Payment plans can be arranged with a credit card guarantee of payment on file. Any returned checks will result in a $15 fee plus original amount of the check.
I have read and understand the payment policy of Advanced Correction Chiropractic and Physical Therapy and understand that my insurance is an arrangement between myself and my insurance company, NOT between Advanced Correction Chiropractic and my Insurance company. Any delinquent accounts are subject to 10% annual interest and other collection, lawyer and court fees after 60 Days of nonpayment.

PATIENT SIGNATURE_____