Sheitelman Medical & Chiropractic Center

WELCOME TO OUR OFFICE. PLEASE FILL OUT THESE FORMS COMPLETELY. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

PATIENT INFORMATION

PATIENT NAME _____ DOB (MM/DD/YYY) _____ [ ] MALE [ ] FEMALE

PATIENT SS# ____-____-_____ PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____ SECONDARY PHONE _____

EMERGENCY CONTACT NAME _____ PHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

PRIMARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY # _____

GROUP # _____

PROVIDER ID # FOR INSURANCE _____

SECONDARY INSURANCE _____

SECONDARY INSURANCE PHONE _____

CARDHOLDER _____

CARDHOLDER DOB (MM/DD/YYYY) _____

RELATIONSHIP TO CARDHOLDER _____

POLICY # _____

GROUP # _____

PROVIDER ID # FOR INSURANCE _____

PATIENT EMPLOYER/SCHOOL INFORMATION

(CIRCLE ONE) EMPLOYED RETIRED STUDENT OTHER

OCCUPATION _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE?

[ ] YELLOW PAGES [ ] WEBSITE

[ ] DOCTOR [ ] PATIENT

[ ] FAMILY [ ] OTHER _____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? [ ] YES [ ] NO DATE: _____

TYPE OF ACCIDENT? [ ] AUTO [ ] WORK [ ] HOME [ ] OTHER _____

IS THERE ANY ONGOING LAWSUITES RELATED TO YOUR VISIT TODAY? [ ] YES [ ] NO

ARE YOU CURRENTLY UNDER WORKER'S COMPENSATION? [ ] YES [ ] NO

TO WHOM HAVE YOU MADE A REPORT OF THE ACCIDENT? [ ]AUTO INSURANCE [ ]EMPLOYER [ ]WORKER'S COMP. [ ]OTHER

ATTORNEY NAME & PHONE (IF APPLICABLE) _____

Medical History

PRIOR TREATMENTS

Please ONLY mark the type of treatment(s) you have had in the past and how well they worked .

☐ Injections	☐ Better	☐ Worse	☐ No Change	Type: _____
☐ Physical Therapy	☐ Better	☐ Worse	☐ No Change	How recently? _____
☐ Surgery (back/neck	☐ Better	☐ Worse	☐ No Change	Type of surgery and year? _____
☐ TENS unit	☐ Better	☐ Worse	☐ No Change	
☐ Heat / Ice	☐ Better	☐ Worse	☐ No Change	
☐ Chiropractor	☐ Better	☐ Worse	☐ No Change	
☐ Acupuncture	☐ Better	☐ Worse	☐ No Change	
☐ Massage	☐ Better	☐ Worse	☐ No Change	
☐ Physiology	☐ Better	☐ Worse	☐ No Change	

MAJOR EVENTS/ HOSPITALIZATION / SURGERY

Have you had any surgery for a problem in this same body area either recently or in the past? ☐ Yes ☐ No

Please list any operations or hospitalization you have had. The year, Surgeon and city they took place.

Type	Year	Surgeon	City

ALLERGIES

Do you have any history of an allergic reaction to medications or other substances?

☐ No Know allergies ☐ Yes, specify: _____

Have you ever had an allergic reaction to: ☐ Iodine? ☐ Contrast? ☐ Latex? ☐ Dental Numbing Medication?

ONGOING MEDICAL PROBLEMS

Do you have a history of any of the following?

Depression	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Attention deficit disorder	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Obsessive compulsive disorder	☐ Yes	☐ No	Heart attack / disease	☐ Yes	☐ No	Peptic ulcer disease	☐ Yes	☐ No
Schizophrenia or bipolar	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Abused during childhood	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Kidney or Liver disease	☐ Yes	☐ No
Hepatitis (A B C)	☐ Yes	☐ No	HIV and AIDS	☐ Yes	☐ No	Hypothyroidism	☐ Yes	☐ No

Other Past medical history: _____

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ Coumadin/Warfarin ☐ Aspirin ☐ Plavix ☐ Aggrenox ☐ Ticlid ☐ Brilinta

Please list any and all medications you are currently taking:

_____

_____

_____

_____

_____

FAMILY HISTORY

Is there a family history of any of the following?

Alcohol Abuse	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Illegal Drug Use	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Prescription Drub Abuse	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Other: _____		

SOCIAL HISTORY

Occupation:_____ When was the last time you worked? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Surgery (back/neck ☐ Better ☐ Worse ☐ No Charge

Tobacco: ☐ Yes ☐ No How many packs a day? _____ How many years? _____ ☐ Quit _____ years ago.

Alcohol: ☐ Yes ☐ No How much do you drink daily? _____ ☐ Quit _____ years ago.

Have you ever drank heavily or abused alcohol? ☐ Yes ☐ No

Have you ever used illicit substances? ☐ Yes ☐ No Type: _____

Have you ever been addicted to or misused prescription drugs? ☐ Yes ☐ No

REVIEW OF SYMPTOMS

Have we failed to ask you anything that you believe is important for us to know?

I certify that the above information is true and correct to the best of my know lege.

Patient / Representative Name: _____

Signature: _____ Date: _____

For Office Use Only

Reviewed by: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC & MEDICAL CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health Is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.
If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

SIGNATURE _____ DATE _____

COLLECTION DISCLOSURE

You agree, in order for our collection company to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing service, as applicable.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

BORROWER / CUSTOMER SIGNATURE _____ DATE _____

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Note: This office reserves the right to make future changes to these and other policies concerned with the retaining, releasing, and maintaining the privacy of patient health information, and I understand that such changes will become retroactive, and therefore no notice to me will follow.
I have read the Sheitelman Chiropractic's Patient Privacy Notice and understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information presented to me on this subject.

PATIENT / INSURED'S SIGNATURE _____ DATE _____

Sheitelman Medical & Chiropractic Center

PRACTICE FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benets. In order to achieve this goal, we need your assistance and understanding of our nancial policy.

On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date, this is your verication of the correct insurance and consent to bill them on your behalf.
IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.

CO-PAYMENTS /CO-INSURANCE AND DEDUCTIBLES: These payments must be made at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments/co-insurance and deductibles from patients is considered a violation of contract and fraud. Please help us uphold the law by making your co-payments/co-insurance at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance).

CLAIM SUBMISSION: As a courtesy to you, we will process and le your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with their request. If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility. We encourage you to contact your insurance carrier personally in order to remain informed of your benets.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every eort to ascertain your coverage for our services before treatment and make you aware of our ndings. However, this does not guarantee payment from your insurance carrier. For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benets allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency, and your account will become inactive until paid. Account balances turned over to a collection agency will accrue interest at the rate of 16% per annum, or 1.33% per month after 90 days. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, ling fees, and service fees.
All Returned Checks Are Subject to a $30.00 Fee. We realize that temporary nancial problems may aect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our Practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our nancial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage.
We are here to help!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.

I hereby authorize photocopies of this form to be as valid as the original.

SIGNATURE: _____ DATE: _____

- ❑ I have Medical Insurance
- ❑ I want Sheitelman Medical to Bill my Insurance
- ❑ I DO NOT want Sheitelman Medical to Bill my Insurance

Dr. David Sheitelman & Associates • 13761 W Bell Rd. Ste. 203 Surprise, AZ 85374 • 623-214-7600 • 623-214-7662 fax

Insurance Waiver

Advanced Beneficiary Notice
Notice of Likelihood of Insurance Denial

We at Sheitelman Medical and Chiropractic are committed to providing quality medical and chiropractic care with transparent fees. We recommend services and or procedures which your Insurance company _____ might deem:

1. Not Medically necessary benefit under your insurance plan or
2. Investigational under your insurance medical policy guidelines

We at Sheitelman Medical and Chiropractic believe that these procedures, injections or supplies are recommended for quality care by our Physicians.

These services are offered at our facility on a cash basis only. We will not bill your insurance and a Sheitelman representative will discuss the cost and necessity prior to providing these services or items with you.

- X-rays
- Injections
- Pre-op Exams
- Extra Extremities Adjustments
- Manual Therapy
- Patient did not have card at the time of service. Patient is indicating that they are covered. If patient is not covered, ineligible or we are unable to verify insurance eligibility and benefits, patient agrees to pay Sheitelman Medical and Chiropractic any amount due from the date(s) of services.

Beneficiary Agreement

I acknowledge the above statement and agree to comply with the statement and Sheitelman Medical and Chiropractic policy.

Beneficiary Signature

Signed_____ Date_____