JOHNSON CHIRORACTIC CLINIC P.C.
DR. KEVIN JOHNSON
5021 W. St. Joseph Ste 6
Lansing MI 48917

# Chiropractor Intake Form

**Title:** (Circle one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

**First Name** _____ **Middle Initial** ____ **Last Name** _____

**Address** _____

**City** _____ **State** _____ **Zip Code** _____ - _____

**Leave Messages on:** (Circle one) Home Cell. Work Don't leave messages

**Home Phone** (____) _____-_____ **Work Phone** (____) _____-_____

**Cell Phone** (____) _____-_____ **Email** _____

**Date of Birth** ____/____/____ **Sex:** ☐ Male ☐ Female

**Social Security Number:** _____-____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

**Employment Status:** ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other____

**Employer Data** _____

**Employer** _____

**Your Occupation** _____

**Spouse Data** _____

**First Name** _____ **Middle Initial** ____ **Last Name** _____

**Home Phone** (____) _____-_____ **Work Phone** (____) _____-_____

**Spouse Date of Birth** ____/____/_____

**Emergency Contact** _____

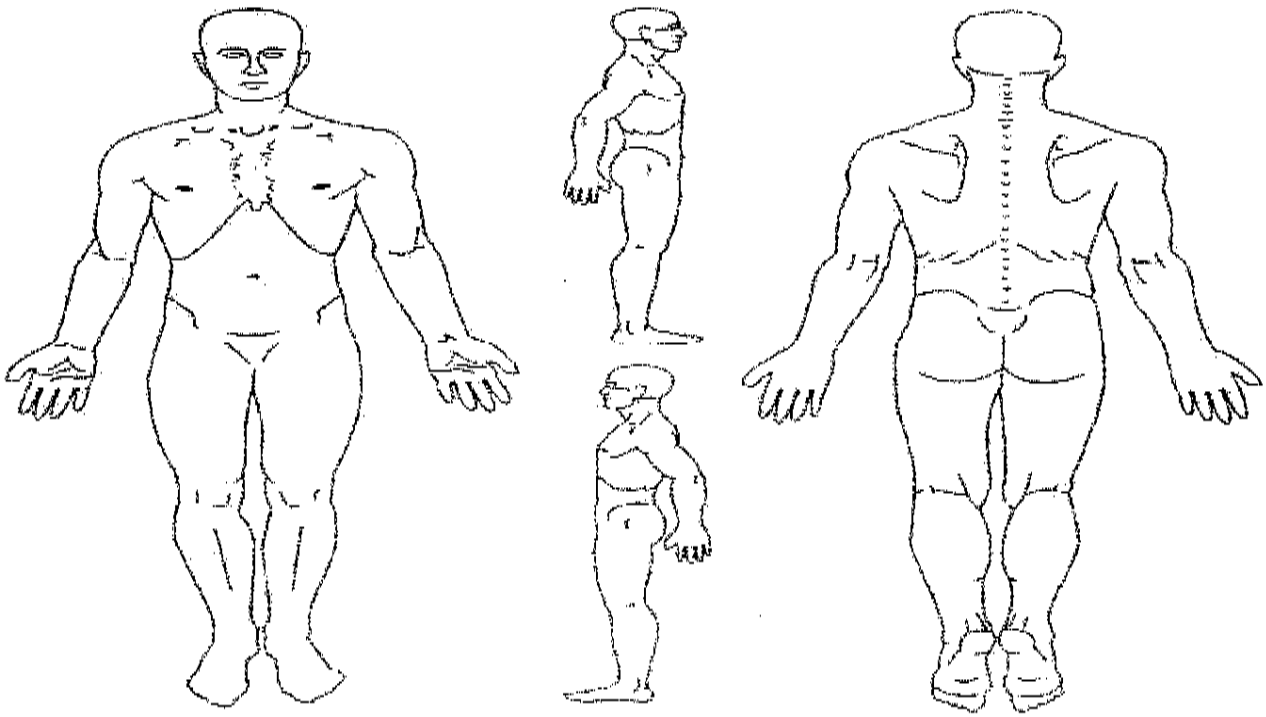
**Contact Name** _____ **Relationship to Patient** _____

**Contact Home Phone** (____) _____-_____ **Cell Phone** (____) _____-_____

Doctor's Signature _____

**By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:**

**N=Numbness** **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



**Average Pain Intensity:**

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**Does anything improve your pain?** Yes No **If Yes, please list:**

**When did your symptoms begin?** _____

**Are your symptoms a result of:** ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other____

**How did your symptoms begin?** _____

_____

**How often do you experience your symptoms?**

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

**What describes the nature of your symptoms?**

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting

☐ Burning ☐ Tingling ☐ Throbbing ☐ Other _____

Doctor's Signature _____

Patient Name_____ Date_____

## PAYMENT POLICY

Thank you for choosing _____ as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $ 10 .00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

**I have read and understood the payment policy and agree to abide by its guidelines.**

_____ _____

**Signature of patient or responsible party** **Date**