Capac Chiropractic

Name _____ ☐ Female ☐ Male Date _____

What you prefer to be called _____Age _____ Date of birth _____

Address _____ City _____State _____Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer _____ Occupation_____ Work Phone _____

Emergency Contact _____Relation _____ Phone _____

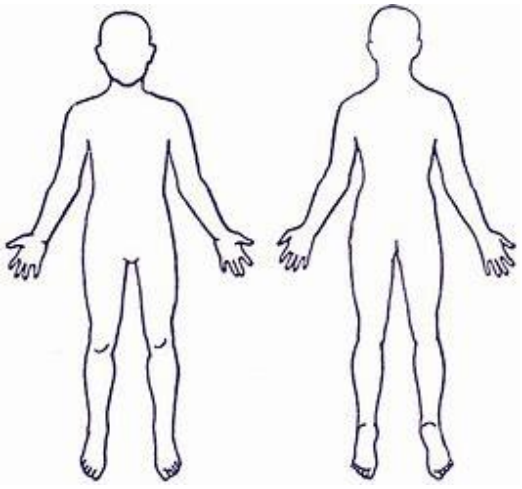
How did you hear about our office? _____

When did your condition begin? _____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? Yes ☐ No ☐ Date of prior condition _____

List chief symptoms in order of severity:



(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician _____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications:_____

_____

_____

_____

Allergies (Medicine, Food, Environment) _____

_____

Previous Surgeries _____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

☐ Headaches	☐ Tingling/Numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/Numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other_____		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health Insurance

Policyholder Name _____Date of Birth _____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes ☐ No ☐ Have you reported it? Yes ☐ No ☐

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to Automobile Accident? Yes ☐ No ☐ Date of accident _____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone #_____

Attorney Name _____ Phone #_____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

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 making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. 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. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Todd Grubb and his affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Dr. Grubb, for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct Premier Rehab, Ltd., it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____

Capac Chiropractic
Financial Policy

 Health Insurance Our office representative confirmed your chiropractic benefits with your insurance company. The following is a summary, although not a guarantee, of benefits quoted:

Primary **Secondary**
Deductible _____ Amount Remaining _____ Deductible _____ Amount Remaining _____
Copay: _____ Limits: _____Year Copay: _____ Limits: _____Year

All co-payments, deductibles and co-insurance amounts are due at the time of service. _____

 Medicare The only service covered by Medicare is the spinal manipulation.
Our office **does not** accept assignment from Medicare, however, we will file your claims to Medicare. Medicare will then forward claims to any secondary payor.
The cost for chiropractic treatment is $___ or $___depending on the number of areas treated.
Medicare will reimburse you for 80% of the allowed.
Medicare patients must sign a waiver acknowledging they are aware that Medicare may not cover the prescribed treatment and they are financially responsible for any denied claims.

_____

 Managed Care Medicare If you participate in a managed care program for Medicare (i.e. United Healthcare), your benefits may be enhanced or limited. When required by your plan, you may be responsible for obtaining a referral from your Primary Care Provider.
Copay: _____ Referral required _____

_____

 Workers Compensation When workers compensation insurance applies, it usually pays 100 percent of the bill. **Please notify us on your first visit if you are planning to file a workers compensation claim with your employer.**

_____

Attorney's Name _____

 Automobile Accident Medical Payments When Med Pay applies, medical bills are paid as they are incurred. In the event med pay amounts are exhausted, we will submit claims to the third party payer. We are willing to wait a reasonable amount of time for the insurance company to pay or settle, but we require a lien from a recognized attorney or a guarantee of payment from the insurance company.

_____

Attorney's Name _____

 Personal Injury When personal injury or liability insurance applies, it usually pays 100 percent of the bill when settlement is reached. We are willing to wait a reasonable amount of time for the insurance company to pay or settle, but we require a lien from a recognized attorney or a guarantee of payment from the insurance company. Otherwise, one of our other payment options must be utilized. If for any reason the insurance company denies payment or fails to pay as much as anticipated, you are responsible for the unpaid amount. You will receive a monthly account statement to keep you updated. _____

Attorney's Name _____

If you have any further questions regarding our office financial policy, please contact our insurance representative.

I have read and understand this financial policy. I understand that I must pay for any out-of pocket expenses at the time of service. Furthermore, I understand that I am ultimately responsible for any outstanding balance on my account.

Signed_____Date_____

Office Financial Policy

It is our office policy that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment.

1. Patients without insurance:

All payments are expected at the time of service or preset on a payment plan or program. Personal balance should not exceed $150 at any time, unless on a prearranged payment plan.

2. Patients with insurance:

Deductibles and all co-payments are expected at the time of service or preset on a payment plan. Your patient responsibility balance should not exceed $150, unless on a prearranged payment plan.

It is the policy of this office to extend to our patients the courtesy of assigning your insurance benefits directly to us. We are happy to extend this credit to you so that you can follow through with all the care you may require. The following are important points of consideration to be aware of:

1. The privilege of insurance assignment begins when our office receives and verifies your insurance information.

2. As a courtesy to you our office will pre-qualify your insurance coverage. To help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

3. As a courtesy, this office will submit secondary insurance, if necessary.

4. If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and act with your insurance company at that time. If it remains unpaid within 90 days, the balance becomes due and payable immediately and your assignment is revoked.

5. All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness club plans to allow you to continue needed care.

6. No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

7. Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

8. The goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know.

Signed: _____ Date: _____