Instructions for new patient paperwork

1. Call our office or send us an email request to set up an appointment time.

2. Print out the following paperwork.

3. Fill out as completely as possible. If you have any questions, feel free to call our office at 504-888-1185.

4. Be sure to bring the following items with you to your appointment:

    - Photo ID
    - Insurance ID Card
    - Completed Paperwork

We would like to take this opportunity to thank you for choosing our practice for your chiropractic care.

PATIENT RECORD

CUPP CHIROPRACTIC CLINIC

DR. REE ANN CUPP

OFFICE USE ONLY
Date: _____
File #: _____

Name: _____ Age: _____ Date of Birth: _____ / _____ / _____

Street: _____

City: _____ State: _____ Zip: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Marital Status (Check) ☐ Single ☐ Married ☐ Widowed ☐ Divorced How Many Children: _____

Spouse's Name: _____ Phone: _____

Employer: _____ Occupation: _____

Other Nearest Relative: _____ Phone: _____

List present complaints and duration:

1._____

_____

2._____

_____

3._____

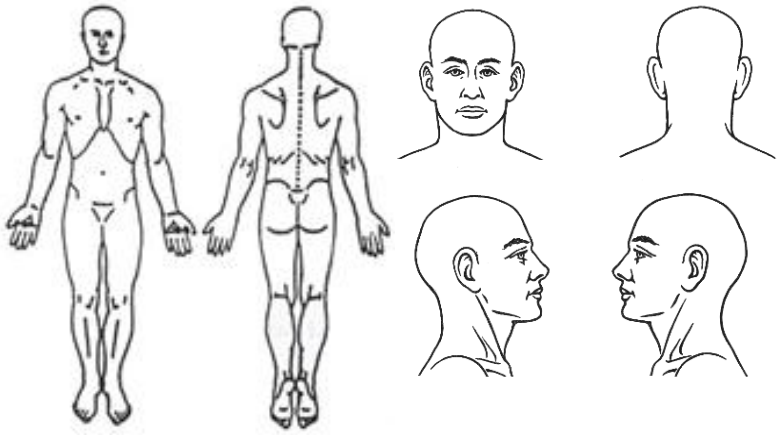
_____

Medications: _____

_____

_____

Please mark your areas of pain on the figures below.



Remarks: _____

_____

Referred by: ☐ Friend _____ ☐ Phone Book ☐ Insurance Company ☐ Other _____

Insurance Company: _____

Type of Coverage: ☐ Group Health ☐ Worker's Comp ☐ Personal Injury (Auto Acc.) ☐ Other _____

In order to file your insurance claims, please fill out the following for your policyholder: Date of Birth ____ /____ /____

Policyholder Name: _____ Social Security Number: _____

I understand and agree to authorize Dr. Ree Ann Cupp, D.C. and all employees to administer whatever examination procedures and treatment as they deem necessary.

Patient's Signature: _____ Date: _____

Patient or Guardian's Signature Authorizing Care:_____ Date: _____

AUTOMOBILE OR WORK INJURY QUESTIONAIRE

Date of Accident: _____ Hour: _____ ☐ AM ☐ PM Location: _____

How Did Accident Occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

Please Describe the Accident or Injury _____

_____

_____

COMPLETE THIS SECTION ONLY IF WORK INJURY

If work related, did you report the injury to your foreman or employer? ☐ Yes ☐ No

Name of Foreman or Authorized Person _____ Phone Number: _____

COMPLETE THIS SECTION ONLY IF AUTOMOBILE ACCIDENT

If auto accident, were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Did your vehicle strike the other(s) involved? ☐ Yes ☐ No Number of people in your vehicle: _____

Or, did the other vehicle strike yours? : ☐ Yes ☐ No ☐ Undetermined

Did the police come to the site of the accident? : ☐ Yes ☐ No

As a result of the accident were traffic citations issues to you? : ☐ Yes ☐ No

To the driver of the other vehicle? : ☐ Yes ☐ No; To the driver of your vehicle? : ☐ Yes ☐ No

Your vehicle Make / Model: _____ Other vehicle Make / Model: _____

Speed of your vehicle _____mph Speed of other vehicle _____mph Did Air bags Deploy? : ☐ Yes ☐ No

List the extent of the injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? : ☐ Yes ☐ No

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

☐ Headache ☐ Neck Pain ☐ Neck Stiff ☐ Sleeping Problems ☐ Back Pain ☐ Nervousness ☐ Shortness of Breath
☐ Irritability ☐ Feel Cold ☐ Hands Cold ☐ Stomach Upset ☐ Constipation ☐ Diarrhea ☐ Cold Sweats ☐ Tension
☐ Ears Ring ☐ Buzzing in Ears ☐ Face Flushed ☐ Loss of Balance ☐ Fainting ☐ Loss of Smell ☐ Loss of Taste
☐ Dizziness ☐ Fever ☐ Pins & Needles in Arms ☐ Pins & Needles Numbness in Fingers ☐ Numbness in Toes
☐ Chest Pain ☐ Failure ☐ Depression ☐ Light Bothers Eyes ☐ Loss of Memory ☐ Head Seems Too Heavy
Symptoms other than above: _____

Have you had similar accidents or injuries before? : ☐ Yes ☐ No If yes, when? _____

Have you lost any days at work? : ☐ Yes ☐ No If yes, dates: _____

Insurance Companies involved:

Your company: _____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? : ☐ Yes ☐ No

If yes, Name: _____ Phone Number: _____

Do you have an attorney that has advised you in this case? : ☐ Yes ☐ No If yes, Phone Number: _____

Attorney's Name: _____ Address: _____

PERSONAL & FAMILY HISTORY

Name: _____ **Date:** _____

PERSONAL	YES	WHEN	YES	FAMILY (SPECIFIC MEMBER)
ABDOMINAL BLEEDING				
ALLERGIES				
ANEMIA				
ARTHRITIS				
ASTHMA / EMPHYSEMA				
BACK DISORDERS				
BED WETTING				
BLACK TARRY STOOLS				
BLEEDING DISEASES				
BLOOD IN STOOL				
BLOOD IN URINE				
CANCER				
CHANGE IN BOWEL HABITS				
CHEST PAIN				
COLITIS				
CONSTIPATION				
COUGH				
COUGHING BLOOD				
DEPRESSION				
DIABETES				
DIAHRREA				
DIFFUCULTLY SWALLOWING				
DIZZINESS				
ENLARGED HEART				
DOUBLE VISION				
EPILEPSY				
FAINTING SPELLS				
GALLSTONES				
GALL BLADDER DISORDER				
GLAUCOMA				
HEADACHES				
HEART DISEASE				
HEART MURMUR				
HEPATITIS				
HOARSENESS				
HIGH BLOOD PRESSURE				
INDIGESTION				
IRREGULAR HEART BEAT				
KIDNEY INFECTION				
KIDNEY STONE				
LEG PAIN				
LUNG DISEASE				
LYME DISEASE				
NOSEBLEED				
NERVOUS DISORDER				
PAINFUL URINATION				
PARALYSIS				
PHLEBITIS				
PLEURISY				
PNEUMONIA				
PUS IN URINE				
RHEUMATIC FEVER				
STROKE				
SWELLING OF FEET				
SWOLLEN / PAINFUL JOINTS				
T.B.				
THYROID DISEASE				
ULCER				
VENERAL DISEASE				
VOMITED BLOOD				
OTHER				

Name: _____ **Date**: _____

PERSONAL HABITS

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential.
Please rate your answer on a scale of 1 to 5 (1 = No/Never, 5 = Yes/Often).

	1	2	3	4	5	ELABORATE
Exercise Regularly (3 to 4 x						
Wear Seat Belts						
Use Illegal Drugs						
Drink Alcohol						
Smoke						
Chew or Dip Tobacco						
Experience Stress						
Other						

WOMEN ONLY

Menstrual Periods: Age of Onset: _____ Regular?: _____ Date Last Period Began: _____ Age Menopause: _____

Difficultly with Periods?: _____Yes _____No Specify: _____

Number of Children: Born Alive: _____ Caesarean: _____ Premature: _____ Stillborn: _____ Miscarriages: _____

Describe Complications: _____

_____

_____

Have you ever been referred to a specialist? _____Yes (Please Elaborate) _____No

_____

_____

_____

Have you ever been in an accident? _____Yes (Please Elaborate) _____No

_____

_____

_____

Are there any environmental risks involved in your job or home environment? _____Yes (Please Elaborate) _____No

_____

_____

_____

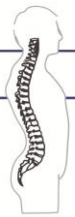
MILITARY SERVICE

Which branch of service did you serve in? _____ Length of enlistment? _____ From: _____ To: _____
Did you sustain any injuries? _____Yes (Please Elaborate) _____No

_____

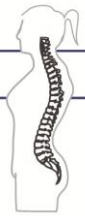
_____

_____



CUPP CHIROPRACTIC CLINIC

DR. REE ANN CUPP



Patient Disclosures and Authorizations

Please read the following information and initial in the appropriate sections.

Insurance Coverage

Welcome to Cupp Chiropractic Clinic. We will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the policy holder to pay co-insurance, co-payment and/or a deductible. If we are a participating provider for your specific insurance company, then we will abide by our contract fees, which include your co pay and/or deductible responsibility. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

I understand and agree that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable.

Patient Initials _____

Missed and/or Late Appointments

It is the policy of Cupp Chiropractic Clinic to assess a **$15.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice.** One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. It is also the policy of Cupp Chiropractic Clinic to **reschedule any appointment that a patient is more than 15 minutes late to.** This clinic provides care for many individuals and late or missed visits result in time lost that could have been used to provide care for others in need.

Patient Initials ____

Consent for Use or Disclosure of Health Information

Privacy Pledge

We are very concerned with protecting your privacy. While the law prohibits our office from selling your protected health care information and requires us give you this disclosure, please understand that we have and always will, respect the privacy of your health care information. Our office will make you aware of any breach of your protected health care information.

Medical Release

There are several circumstances in which we may have to use or disclose your health care information:

~ To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

~ To another party if they are potentially responsible for the payment of your services.

~ To family and/or friends who were involved in providing care or payment for care in the event of the patient's death. This HIPAA Protection is void 50 years after a patient's death.

~ To an insurance company, adjuster or attorney in order to process any claims for reimbursement of charges incurred by me.

~ Within our practice for quality control or other operational services such as sending the following products to you: Appointment reminders, Birthday cards, Newsletters, Thank you cards, and any and all correspondence with Dr. Cupp.

~ To the Chiropractic Association of Louisiana if we need the CAL's assistance to receive reimbursement for your services or because the party responsible for reimbursing your services has improperly processed your claim. By signing this form you are giving CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel and state or federal agencies that may be asked to intercede on your behalf.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health care information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we disclose at any time (ξ 164.524).

I hereby authorize you to release any of my health information in the manner described above.

Patient Initials _____

Assignment, Lien & Authorization for Direct Payments by my Payers to Cupp Chiropractic Clinic

Assignment and Lien Terms

I hereby assign to Cupp Chiropractic Clinic to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles, and remedies that I might have against or with respect to any Payer now or in the future, and the right to prosecute, seek, settle, or otherwise resolve such Claims to Proceeds either in my name or in the Cupp Chiropractic's name. I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to Cupp Chiropractic Clinic a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to, and be effective as of, the date and time that the initial cause of my condition occurred. I further authorize the Cupp Chiropractic to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests, and to make such filings in all relevant jurisdictions as Cupp Chiropractic sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my agreement with Cupp Chiropractic, such security interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, Cupp Chiropractic Clinic to the full extent of my Charges. To the extent that any law, including without limit a lien statute, purports to limit, reduce, or modify the distribution of Proceeds in any manner inconsistent with this Assignment & Lien including without limit through the reservation of a portion of the Proceeds exclusively to me, I hereby waive such limits, reductions, or modifications. Such waiver shall not adversely affect or prejudice any rights which Cupp Chiropractic may have and elect to exercise under said law.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases

In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and Cupp Chiropractic hereby requests) each attorney to provide immediate notice to Cupp Chiropractic regarding such Proceeds, to promptly pay Cupp Chiropractic in-full out of such Proceeds, and to provide a full accounting of such Proceeds. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to Cupp Chiropractic. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require Cupp Chiropractic to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives

I hereby direct each and every Payer to immediately release to Cupp Chiropractic any Pertinent Information relating to (a) any coverage I may have and (b) any Proceeds Determination by the Payer relating to Cupp Chiropractic's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records, and other information (a) relied upon by the Payer in making a Proceeds Determination, or (b) was submitted, considered, or generated in the course of making a Proceeds Determination without regard to whether such document, record, or other information was relied upon in making the Proceeds Determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny, or delay payment of any Proceeds relating to Cupp Chiropractic's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review, or independent medical exam. I further authorize and direct Cupp Chiropractic to release any information relating any services rendered to or for me by Cupp Chiropractic to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed to in writing.

I have read, understood, and agree to the terms of this Assignment & Lien.

Patient Initials _____

Payment for Services

It is the policy of Cupp Chiropractic Clinic to have our patients **make any and all payments due on their account upon arrival** unless otherwise agreed upon.

Patient Initials _____

I understand that all health services rendered to me and charged to me are my personal financial responsibility.

I understand and agree to the conditions of this policy.

I have read and received a copy of this agreement. Patient Initials _____

_____	Dr. Ree Ann Cupp D.C.
Patient Name Printed	**Authorized Provider Representative**
_____	Kristina Mercier or Robin Goljenboom
Patient Signature	**Personal Representative Signature**
_____	_____
Patient Account Number	**Date**