VILLAGE CHIROPRACTIC LLC PATIENT INFORMATION

LAST NAME_____________________ FIRST_____________________ M.I.________

ADDRESS_______________________________________ CITY_____________________

STATE______ ZIP_______________ HOME#_________________CELL#_____________

DOB___________________ AGE____________ SS#__________________________

EMERGENCY CONTACT__________________________________PHONE#_____________

GENDER (please circle) M/ F MARRIAGE STATUS (please circle one) S M D W

HOW DID YOU HEAR ABOUT US? Yellow pages, newspaper, family or friend (if a patient please list who)__________________________, other____________________

Person Responsible for Account

LAST NAME________________________FIRST__________________M.I.__________

ADDRESS_____________________________________CITY_____________________

STATE____________ ZIP____________ HOME#______________ CELL#_________

DOB_________________ SS#________________________

EMPLOYER____________________________ PHONE #________________________

INSURANCE INFORMATION

INSURANCE___________________ ID#_______________________GROUP________

NAME OF INSURED_______________________ DOB ___________SS#___________

PATIENT RELATIONSHIP TO INSURED______________________

INSURED’S EMPLOYER_____________________________ PHONE #____________

INSURANCE__________________ID#_______________________GROUP_________

NAME OF INSURED_______________________ DOB ___________SS#___________

PATIENT RELATIONSHIP TO INSURED______________________
INSURED’S EMPLOYER_____________________________ PHONE #____________

VILLAGE CHIROPRACTIC LLC
7127 HOMESTEAD RD STE E
FORT WAYNE, IN 46814
PHONE: (260)387-5944
FAX: (260)387-5465

Please answer the following in regard to patient privacy:

May we call to remind you of scheduled appointments: Yes ______ No ______

If unavailable, may we leave a message:
1. On your answering machine or voice mail? Yes ______ No ______
2. With another person who answers the phone? Yes ______ No ______

May we call you at work? Yes ______ No ______
If yes, please give your work number: ______________________________________

Your signature indicates your authorization.

____
Name (printed)

____
Signature

____
Date

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed. Thank you!

VILLAGE CHIROPRACTIC LLC NEW PATIENT INFORMATION

Please check any condition that you have had or have now:

O Back Pain
O Neck Pain
O Shoulder/Arm Pain
O Hip/Leg Pain
O Sciatica
O Arthritis
O Frequent Infections
O Menstrual Problems
O Other Digestive Problems
O Dizziness
O Loss of Bladder/Bowel Control
O Chest Pain
O Difficulty Breathing
O Asthma
O High Blood Pressure
O Poor Circulation
O Irregular Heartbeat
O Epilepsy
O Diabetes Type I or II
O Recent Weight Gain/Loss
O Fibromyalgia
O Scoliosis/Curvature of Spine
O Colon Trouble
O Stomach/Esophageal Trouble
O Liver Trouble
O Difficulty Urinating
O Kidney Problems
O Easy Bruising
O Prostate Problems
O Tuberculosis/Emphysema
O Anorexia/Bulimia
O Lupus/Autoimmune Disorders

O Heart Attack, When?____________________
O Skin Problems, eczema, Psoriasis, ect..________________________________
O Cancer, What type? _______________ When? ___________What Treatments?_______________________
O Allergies? To what? ____________________
O Other Health Problems/Diseases? ____
O Drug/Alcohol dependence? ____

Please list any medications/Supplements (vitamins) that you take.______________________________________
____
____
____

Please Circle/Have you ever…			**Please describe/date of Occurrence**
Been hospitalized?	YES	NO	____________________
Hospitalized for childbirth?	YES	NO	____________________
(*Number of children and ages*:			____________________
Had a broken bone?	YES	NO	____________________
Had Surgery?	YES	NO	____________________
Been treated for an Emotional disorder?	YES	NO	____________________
Do you have metal In your body?	YES	NO	____________________
Had a car accident?	YES	NO	____________________
Had any recreational Vehicle accident?	YES	NO	____________________
Had any slips, falls or accidents of significance?	YES	NO	____________________
Do you smoke or use Tobacco Products?	YES	NO	____________________

Family History:

Parents Living / Deceased If deceased what was cause of death? ______________________________
Siblings Living / Deceased If deceased what was cause of death? ______________________________

<u>**Village Chiropractic LLC Patient Information**</u>

Name________________________ DOB________________ Age______________

Family Physician____________________________ Phone #_____________________

May we send your physician health records? (circle one) Yes / No

Have you ever seen a chiropractor before? Yes/ No. If yes, when was your last visit ____

Chief Complaint/Reason for coming here? (please Describe) ______________________

____

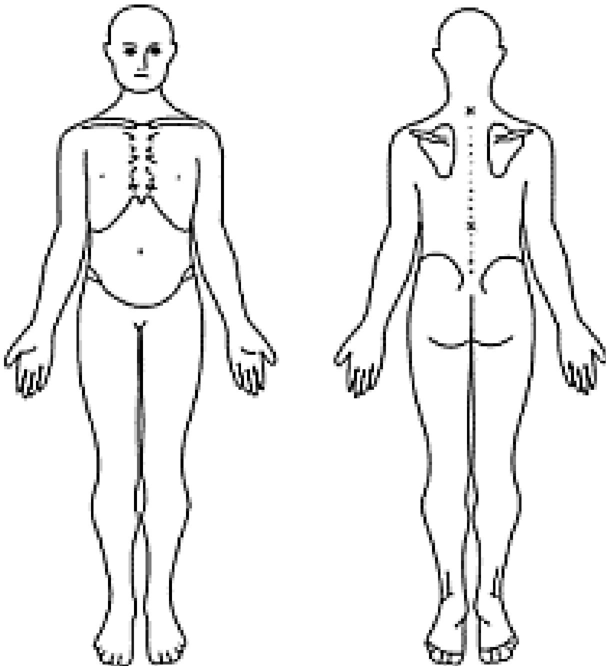
When did these symptoms begin?____

Does anything make the symptoms better or worse? _____________________________

What functions or activities do you have difficulty in performing? _________________

____

Please mark any areas of pain on the figures below:



VILLAGE CHIROPRACTIC, LLC
FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement. ________

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's 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, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately. _______

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately._______

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional

supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies; Aetna, Advantage Health Solutions, Anthem BCBS, HMO and PPO CAQH, Cigna, Encore (through HSM), Humana, Lutheran Preferred, Medicare, Medicaid, Parkview Signature Care, PHP, Railroad Medicare, Three Rivers Preferred, United HealthCare.

☐ You are required to pay a $______co-pay at the time of service.

☐ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

☐ Benefits are available for up to ______visits per year. A $______co-pay is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.________

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.________

I have read and understand the payment policy of Village Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Village Chiropractic and my insurance company. I request that Village Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Village Chiropractic that fees will be due and payable immediately.

____

Patient's signature (or guardian if patient is a minor) Date

____

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name:_____________________________________

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $___________deductible, $_____________of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving ______% of each visit due by you.
2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $___________deductible, $_____________of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $______co-pay of each visit due by you.

VILLAGE CHIROPRACTIC LLC.
Patient Health Information Consent Form

*We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.*

1. *The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.*
2. *The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.*
3. *A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.*
4. *The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.*
5. *For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.*
6. *Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.*
7. *If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.*

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Name of Patient ***Date***