PATIENT INTRODUCTION

Please answer the following questions completely

Name: _____ SS #: _____

Address: _____ Apt#: _____ City: _____ St: ___ Zip: _____

Home Phone#: (____) _____ Work Phone #: (___) _____

Employer: _____ Occupation: _____

Duties/ Daily Activities @ Work: _____

Sex: M F Marital Status: S M D W Age: _____ Date of Birth: ___ / ___ / _____

How did you hear about our clinic? _____

Describe Problem: _____

Have You had Chiropractic Care before? _____ Yes _____ No If so, Who was the chiropractor? _____

When was your last visit? _____ Where? _____ How were the results? _____

Is it possible you are Pregnant? _____ Yes _____ No Do you have health insurance? _____ Yes _____ No

Are you here because of : _____ An Auto Accident Date injured: ____ / ____ / _____

_____ An on the job injury Do you have an attorney? _____ Yes _____ No

Date of last physical exam: _____ / ____ / _____ Reason: _____

Please list all accidents, falls, injuries, surgeries, major illnesses, or traumas no matter how long ago they occurred.

TYPE	DATE	DESCRIBE/COMMENTS

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?

NAME OF DRUG	AMOUNT	DESCRIBE/COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

___Headaches	___Head feels heavy	___Heart Pain	___Indigestion
___Shooting head pains	___Dizziness	___Heart Palpitation	___Intestinal Gas
___Sinus Pain	___Fainting	___Mid-Back Pain	___Low back pain
___Loss of smell	___Loss of balance	___Heart Attacks	___Constipation
___Hay fever	___Stress	___High Blood Pressure	___Menstrual Cramps
___Loss of taste	___Muscle spasm in neck	___Anemia	___Menstrual Irregularity
___Tightness in throat	___Grating in neck	___Nervous Stomach	___Diabetes
___Inflammation in throat	___Tight shoulder muscles	___Stomach trouble	___Swelling
___Thyroid Trouble	___Neuritis-arms/shoulders	___Ulcers	___Arthritis
___Face flushed	___Pins and Needles	___Nerves & nervousness	___Ruptured Disc
___Twitching of face	___Arms/hands pain	___Irritability	___Pinched Nerve
___Loss of memory	___Cold hands	___Cold sweats	___Night sweats
___Irregular sleep	___Fatigue	___Chest pains	___Liver trouble
___Leg/Feet pain	___Depression	___Shortness of breath	___Gallbladder trouble
___Neck pain	___Ringing in ear(s)	___Cold/Heat intolerability	___Allergies

___Other: (please explain:) _____

Are any of your family members experiencing any of the above difficulties?

Family members: _____ Difficulties: _____

_____ _____

_____ _____

Do you have any family history of diseases? If so, please explain: _____

_____

Amount of sleep you get per night (hours): _____ Position you sleep in at night: _____

Is your sleep: Great Good Fair Poor

PRESENTLY: Quality of Life Value (1-100): _____

Performance Level of Daily Functions (1-100): _____

PAYMENT/INSURANCE INFORMATION

Please complete all applicable information

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
S A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU

( ) **CASH/CHECK:** Payment is due in full when services are rendered.

( ) **INSURANCE:** We will file your medical insurance for you. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **AUTOMOBILE INSURANCE:** We must have verification of insurance, a copy of your insurance card, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **WORKER'S COMPENSATION:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.

( ) **MEDICARE:** We must have a copy of your Medicare card or verification of coverage.

Insurance Information:

Insured's Full Name: _____ Insured's Date of Birth:__/__/___
Relationship to the Insured: _____ Home Phone: (__)_____
Insured's SS #: _____
Insurance Company Name: _____
Insurance Company Phone Number: (__)_____ Group #: _____
Insured's Employer: _____ Phone #: (__)_____

I _____, have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, I understand that I will be responsible for ALL fees incurred(attorney fees, collection agency fees, court costs, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Patient Signature:_____ Witness: _____
Date: _____

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS

MEDICARE DOES COVER CHIROPRACTIC!...BUT WITH LIMITATIONS. Medicare requires that you have an **examination** performed to identify a vertebral misalignment "subluxation" to necessitate the need for chiropractic adjustments. They WILL NOT however pay for **this examination.** One method of determining a vertebral misalignment is present in your spine is via an x-ray. Our office policy states that we require an x-ray be performed on you to visualize a spinal misalignment, once again, to allow medicare to substantiate paying for your chiropractic adjustments. Medicare WILL NOT pay for these **x-rays** either. Both the examination and x-ray are the financial responsibility of the patient unless a secondary insurance will cover these procedures.

Your condition may require more treatments or additional therapies that medicare will not pay for. MEDICARE WILL ONLY PAY FOR A CHIROPRACTIC ADJUSTMENT TO THE SPINE!.... NOTHING ELSE!!! These additional services can aid in you holding your adjustments longer, make the adjustment less discomforting, benefit other health related issues, make the surrounding soft tissue more pliable and a variety of other health benefits. MEDICARE WILL NOT pay for these services. If you have a secondary insurance, they may pay for these services, which we will verify with your secondary insurance if they cover the procedures or not. In the case they do not cover these services, you as the patient are responsible for the payment if you decide to obtain these additional services. You always have the option of declining these additional ancillary services. We will however recommend them to you and if you do not wish to utilize them, PLEASE LET US KNOW!

The cost of ALL (excluding x-rays and exam) of the additional therapies (that Medicare does not pay for) that are performed in conjunction with your adjustment for that day is a **$40** additional charge. So to break a medicare office visit down, Medicare pays for the adjustment only and the patient pays a **$40 co-pay** for the additional therapies provided.

*** **$40 Co-Payment**.....covers ALL additional therapies performed under the chiropractic OFFICE VISIT. (Does Not Cover the Cost of the Exam and X-rays)

(A) Notifier(s):

(B) Patient Name: (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) Additional Services (A.S.) below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) Additional Services (A.S.) below.

(D) Additional Services (A.S.)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
- INITIAL EXAM	NOT A REIMBURSABLE PROCEDURE BY MEDICARE WHEN PERFORMED BY A CHIROPRACTOR	50
- X-RAYS		50
- LASER THERAPY		~50
- KINETIC ACTIVITY		~50
- MASSAGE / INTERSEGMENTAL TX		50
- NEUROMUSCULAR REEDUCATION		50
- THERAPEUTIC EXERCISE		~50

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) Additional Serv. listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the (D) (A.S.) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the (D) (A.S.) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

❑ **OPTION 3.** I don't want the (D) (A.S.) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:

FLORIDA CHIROPRACTIC CLINICS

PATIENT AND DOCTOR AGREEMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that we will be using to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than to correct vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method to achieve this is specific chiropractic adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room) and that I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

FLORIDA CHIROPRACTIC CLINICS, INC.

OFFICE POLICIES AND GUIDELINES PERTAINING TO APPOINTMENTS

MISSED APPOINTMENTS and FINANCIAL AGREEMENTS

Our facility attempts to accommodate our patients by giving appointments that meet their schedules. We understand that things pop up prior to or at the last minute. As a courtesy we appreciate a phone call letting us know that you will be late or not be able to attend and thus, we can modify our schedule accordingly. Numerous times, other patients wish to obtain an office visit at the same time as what you wish to as well. We only have a certain number of time slots available to accompany our patients. If you can not make your scheduled appointment and you call in, we can fill your time slot with another patient who wishes to come in. Our office feels this is a common courtesy to us, you and other patients. However, others may not feel that way as we still encounter situations where patients do not notify us of not being able to meet their appointment. As a result, our office has a $30 fee for any patient that fails to notify the office of a cancellation, regardless if you are a cash, insurance, or automobile accident patient.

You have two options. Please provide your initials by your choice below.

____ Option A. I am providing a undated check made out to Florida Chiropractic in the amount of $30.00. This check is to be on file to cover any missed appointment that I fail to call and cancel. If I do not violate this policy, the **CHECK WILL NEVER BE CASHED.**

____ Option B, I am providing to Florida Chiropractic Clinics, Dr. Greg Yingling, my credit card information. The amount of $30.00 will ***ONLY BE CHARGED*** TO MY CREDIT CARD ***IF I FAIL*** to call and cancel a scheduled appointment. ***Shall I not violate this policy, UNDER NO*** circumstances will *MY CARD BE BILLED* or my information shared.

Card Holders Name (as on front of card) _____

Type of Card: *Visa* *MasterCard* *Card #* _____ Exp Date: ___/___

Three or four digit number on the back of the card on the signature line ____ ____ _____ _____

_____ _____

Patients Signature Date

Cc: patient