Creekside Chiropractic Center

Confidential Patient Information and Consent

1

Legal Name: _____
(Last) (First) (Middle Initial)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: Home_____ **Cell**_____**Cell Provider**_____

Email Address: _____

Would you like to receive appointment reminders through text or email? Circle one **Text** **Email**

I, _____, authorize Creekside Chiropractic Center, Inc. to send Appointment Reminders electronically via text message/email listed above. Standard text messaging rates may apply.

Birth Date: _____ **Sex:** Male Female **Status**: Married Single Divorced Widowed Child Other

Social Security # _____

Whom may we thank for referring you? _____

Employment Status: Employed Student Retired Child Other **Occupation:** _____

Patient Employer/School: _____ **Work Phone:** _____

Primary Care Provider Name: _____ **Location:** _____

Permission to contact? Yes No

Have you had any X-Rays/MRI's/CT's taken in the last year? Yes No If yes, where? _____

2

☐ **We link patients in a household for statement purposes, to show credit and balance in the household. Please initial and sign if you authorize the transferring of credits from account (s) to other account(s) within a household.**

Signature: _____ **Date:** _____

In case of emergency, contact: _____ **Relationship:** _____ **Phone:** _____

Our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family members you must sign below. Signing this form will only give information to family members indicated below. By signing this, I understand that I give authorization to Creekside Chiropractic Center, Inc to release my medical and/or billing information to the following individuals. If I do not wish to release this information, I will leave it blank.

_____ **Relation to Patient:** _____

_____ **Relation to Patient:** _____

Signature: _____ **Date:** _____

For Office Use Only: Received by: _____Input:_____ Scanned:_____ Date:_____ Dr. Review:_____

ke 1/8/19

Creekside Chiropractic Center

Confidential Patient Information and Consent

3

Payment/Insurance Information

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Name of Insurance Company: _____ Policy ID Number: _____

Relationship to Policy Holder **(circle one):** Self Spouse Child Other Do you have an HRA/HSA/FSA? Yes No

Insurance-As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not the insurance company. **Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.**

Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. You are responsible for all services billed and any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co-payments at the time of service.

Cash Services - Time of Service (TOS) - We request that 100% of payment is made at the time of service. If your situation requires that you are a self-pay patient (e.g. you are uninsured, chiropractic benefits have been exhausted or your co-pay or out of network deductible is extremely high), please inquire with the front desk about our cash services policy.

Referrals / Pre-authorizations- If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in a denial of payment from your insurance company. You would be responsible for any unpaid balances.

Medicaid- If you have Medicaid, most of your services, with the exception of supports/vitamins and supplies, will be covered 100% under you Medicaid plan. You will be required each MONTH to show proof of continued Medicaid coverage.

Financial Hardship- It is unlawful to routinely waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per the Federal False Claims Act, Federal Anti-Kickback Statute, State and Federal Insurance Fraud Laws. It is also a violation of our managed care contracts. If you have a true financial hardship, please notify the front desk staff. You will need to provide appropriate documentation that shows you are unable to pay medical bills. All information relating to financial hardship requests will be kept confidential.

Payment Details- All patients' balances are due immediately upon receipt. All dependents and spouses in the same household will be responsible for outstanding balances. Patients with upcoming appointments must pay their balance(s) in full prior to their next appointment.

***By signing below, I acknowledge that I have read and fully understand Creekside Chiropractic Center, Inc's Financial Policy.**

_____

Printed name of Patient

_____

Signature of Patient or Parent/Guardian

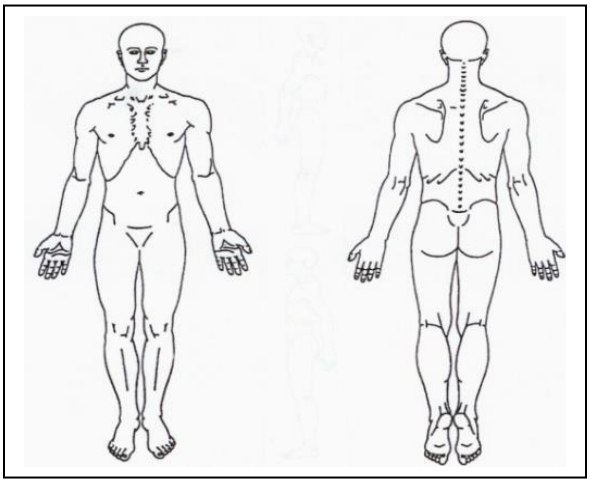
For Office Use Only: Received by: _____Input:_____ Scanned:_____ Date:_____ Dr. Review:_____

ke 1/8/19

Creekside Chiropractic Center

Health History Questionnaire

Please Print Name: _____



1. Please **mark** where you are or have been experiencing pain:

No Pain Very Painful

2. **Circle** your pain intensity: 0---1---2---3---4---5---6---7---8---9---10

3. When did your symptoms start?_____

4. How did they occur? _____

_____

5. How often do you experience your discomfort?_____

_____

6. How would you describe your pain? **Please circle**: Sharp / Stabbing /Burning / Numbness / Tingling / Throbbing /Aching

7. What makes your pain worse?

_____

_____

8. What makes your pain better? _____

_____

9. Have you ever had chiropractic care? ☐ Yes ☐ No Last date of care? _____

10. List all current medications, including over the counter and nutritional supplements you are taking:

_____

11. Have you had a major illness or have had surgery? Please explain:_____

_____

12. Please check items below that pertain to your health **(Check Past or Present) and (Circle all that apply)**

PAST	PRESENT		PAST	PRESENT	
		Smoking/Tobacco Use			Auto Immune Disorders
		Exercise			Respiratory Lung Disorders: (Bronchitis/Asthma/COPD)
		Weight Gain/Loss			Liver Disorders: (Hepatitis/Cirrhosis)
		Fatigue			Urinary Tract Disorders: (Kidney Stones / Chronic Urinary Tract Infection)
		Sleep Difficulties			Reproductive System Disorders
		Arthritis			(Gastrointestinal Disorders: Ulcer / Constipation / Diarrhea / IBS)
		Headache			Endocrine Disorders: (Thyroid / Diabetes / Other)
		Cancer			Please explain below:
		Allergies/Sinus			
		High Blood Pressure			
		Heart Disease			Other disorders not listed:
		High Cholesterol			
		HIV			

Patient Signature: _____ Date: _____