Chiropractic Registration and History

Patient Information

Date _____

Patient ID # _____

Patient Name _____
Last Name

_____ _____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex: ☐ M ☐ F Age _____

Birth Date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Spouse's Birth Date _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____ Alt. Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Alt. Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture to the right where you continue to have pain, numbness or tingling. ▶

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

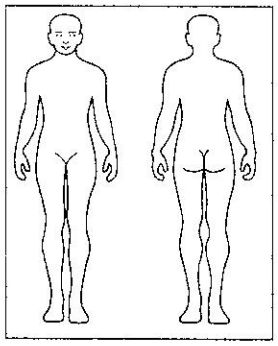
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Mark box "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other ____	
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		

Please mark in each column which boxes best describe your activities:

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone (_____) _____

Pharmacy E-mail (_____) _____

ARNDT FAMILY CHIROPRACTIC

SUBJECTIVE ANALYSIS FORM

Patient Name: _____

Date: _____ Initial or Re-Exam _____

Visual Analog Scale

(please indicate the pain level you are currently experiencing
by writing each involved body area on the scale below)

0 ---------- 10

1 2 3 4 5 6 7 8 9

(no pain) (unbearable pain)

Total all Pain Levels: _____

Activities of Daily Living

People with spinal pain may find that certain activities are restricted or difficult to do.
Please check all activities that you find difficult to do **now**:

____ Sleep through the night
____ Get out of bed
____ Bathe yourself
____ Wash, comb or dry hair
____ Bend over a sink for 10 mins.
____ Go to the bathroom
____ Put on socks, shoes or clothing
____ Walk up one flight of stairs
____ Walk down one flight of stairs
____ Crawl on all fours
____ Turn a door knob
____ Open a heavy door
____ Sit in a chair for 30 mins.
____ Sit and work at a desk for one hour
____ Get up from a low seat
____ Cross legs
____ Walk one mile
____ Stand for 30 mins.
____ Travel on journeys that take over one hour
____ Push or pull vacuum cleaner or lawn mower
____ Carry laundry basket, groceries or a small child
____ Wash windows or walls
____ Bend over to clean bathtub
____ Shovel snow or dirt
____ Use pencil, scissors, screwdriver or pliers
____ Lift a heavy suitcase (approx. 40 pounds)
____ Reach in front or overhead to high shelves
____ Enjoy hobbies or social activities
____ Enjoy sexual activities

Total # ADL items checked _____
Subjective Total _____

Check any of the following conditions you are **currently** experiencing:

____ Neck or back weakness
____ Restricted movement of neck or back
____ Persistent tender areas in muscles around neck or back
____ "Catch" or "Kink" in neck or back

_____ _____

Patient Signature Date

ARNDT FAMILY CHIROPRACTIC

NON-COVERED CHIROPRACTIC SERVICES CONSENT FORM

This Consent is to clarify our policy regarding non-covered services.

Non covered services are those procedures and services deemed not medically necessary by the insurer or their administrator. In this office, our major concern is to assist you in maintaining overall good health. The health plan's chiropractic and therapy benefits are for acute, active therapeutic care. Once your symptoms have been reduced to a level of supportive or maintenance care, or you have utilized all your insurance allowed visits or coverage, the responsibility for payment of services is that of you, the patient.

We believe it is beneficial for the patient to continue supportive or maintenance care on a regular basis in order to maintain correction. If you elect to continue care, please be aware that you are responsible for the continued payment of our services.

If you have any questions regarding your chiropractic insurance benefits you should contact your health plan through your customer service representative.

It is very important that you understand your financial choices in order to alleviate any misunderstanding or confusion between all parties. A list of our *approximate* costs is enclosed in this packet for your review and signature. You also can ask for a separate copy for your reference. We strive to explain to you in advance our costs regarding any procedures or treatments.

We ask that you please sign this Consent Form acknowledging receipt of the above information and your financial responsibility. A copy of this Consent will be maintained in your file should any questions or concerns arise.

As always, it is our mission to provide you with the highest quality of care. Thank you for choosing Arndt Family Chiropractic for your chiropractic care. We look forward to working with you.

DISCLOSURE STATEMENT:
I have read and understand the above information. I understand and accept that I will be financially responsible for full payment of any and all non-covered services.

X _____ _____

Patient Name (please print) Date

X _____

Patient Signature

ARNDT FAMILY CHIROPRACTIC

FINANCIAL AGREEMENT

The purpose of this Agreement is to clarify the financial aspects of your chiropractic care at Arndt Family Chiropractic. By your reviewing this information and signing below, we can devote our efforts to effectively helping you to achieve the best results – in the shortest amount of time.

Services:
Our fees vary based upon the severity of your condition(s) and the amount of time required to achieve the best result. Below are the most common services that we provide.

Procedure	Purpose	When Performed	Fee
Consultation	Tour the office, meet the doctor & staff. Discuss your issue(s) and health history.	Initial Visit	N/C
Examination(s)	Accurately determine the nature of your issue(s) and determine best course of action.	Initial Visit – Repeat every 10th to 15 visit	$50 - $95
X-Ray(s)	Visualize the location of spinal pathologies and confirm other examination findings	If necessary – 1st Visit, Re-injuries. As needed for progress exams.	$25 - $75 Per Region
Evaluation/ Management/ Adjustment(s)	Assess and evaluate Patient's health, determine appropriate course of care and reduce the Vertebral Subluxation Complex, Stabilize spine or joint problems.	Every Visit	$30 - $60
Therapy	Reduce inflammation and swelling, enhance the healing process and help to provide relief	As indicated by exam or office visit	$16 – $28
Laser Therapy	Reduces short term inflammation. Lowers risk of arthritis. Provides deep tissue therapy.	As indicated by exam	$20 - $90

Forms of Payment:
If you have health insurance, managed care, Medicare, Medicaid or personal injury coverage, we will submit the necessary paperwork and billing. Some exceptions may apply. You are responsible for any deductibles, co-pays or charges not covered by your insurance company.

You may also choose the option of paying on the day of service and receiving a day of service discount. We accept cash, personal checks, Visa, Master Card, Discover and AMEX.

Questions:
Please do not hesitate to ask should you have any questions about this Agreement. If your ability to comply with the provisions of this Agreement changes, please let us know. We are here to help.

Patient Agreement:
I have read, understand, agree to and have received a copy/declined a copy *(please indicate)* of this Agreement.

X_____ _____ _____

Patient/Responsible Party Signature | Date | Office Representative

ARNDT FAMILY CHIROPRACTIC

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP HEALTH INSURANCE

RE: _____

Patient: _____

Employer: _____

Claim/Group # _____ SSN _____

I hereby instruct and direct _____ (insurance company) to pay by check made out and mailed directly to:

Tricia L. Arndt, D.C.
7130 Muirfield Drive
Dublin, OH 43017

OR

If my current policy prohibits direct payment to said Doctor, then I hereby also instruct and direct _____ (insurance company) to make the check to me and mail it as follows:

Tricia L. Arndt, D.C.
7130 Muirfield Drive
Dublin, OH 43017

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. *THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.* This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Arndt Family Chiropractic, this _____ day of _____, _____

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, of other than Policyholder

ARNDT FAMILY CHIROPRACTIC

OFFICE POLICY DEFINITIONS

Please initial all that apply:

____ **Payment of Your Bill**
It is the ultimate responsibility of the Patient/Guarantor to pay or provide third-party coverage for payment of all services received at Arndt Family Chiropractic.

____ **Medicare Patient**
We are on assignment with Medicare, therefore, payment will be directly reimbursed to our office based upon Medicare Chiropractic coverage. According to Medicare policy, Chiropractic coverage varies upon each additional patient's condition/diagnosis, therefore, upon termination of Medicare Chiropractic coverage, the Patient is responsible for the deductible, co-pay and office visits at that time.

____ **Medicaid Patient**
If you are a Medicaid patient, and you have provided our office with a valid Medicaid card, we will bill Medicaid for you. If you don't have a valid Medicaid card, your account will be treated as a self-pay account and payment will be expected from you.

____ **Commercial Insurance**
If you have supplied this office with complete insurance information at the time of registration, our office will submit your bill directly to your insurance company. Payment will be expected with 60 days of billing. If payment is not received 60 days, or your insurance company(ies) denies your claim, or the balance due is owing after your insurance company(ies) have paid, your account will be re-classified as a self-pay account, and we will bill you directly.

____ **Worker's Compensation**
If this is a Worker's Compensation claim, and you have a valid claim number, this office will bill the account for you. If you don't have a claim number, it will be your responsibility to complete the necessary forms to obtain a claim number. We will assist you with the necessary forms.

____ **Self-Pay**
If you have no insurance coverage, and you are ineligible for any government programs such Medicare, Medicare, Medicaid, etc., you will be responsible for payment of services provided at Arndt Family Chiropractic. Payment is due at the time of services.

ARNDT FAMILY CHIROPRACTIC

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTCARE OPERATIONS

I, _____, hereby give consent to Arndt Family Chiropractic (the "Practice") to use and disclose my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purpose. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conducted upon my consent as evidence my signature on this document. For purposes of this Consent, "Protected Healthcare Information" means any information, including my demographic information, created or received by the Practice that relates to my past, present or future physical or mental health condition; the provision of health care to me; or the past, present or future payment for the provision of health care services to me, and that either identifies me or from which this is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

Release of Information

- I hereby authorize Arndt Family Chiropractic to release any formation needed for completion of their claims for payment, for continuity of care of for Worker's Compensation claims. This includes, but is not limited to, my insurance company, my employer, any physician, hospital, social agency, welfare agency or governmental agency. I permit release of information concerning dates of chiropractic care, condition, diagnosis, procedures or treatments.
- Arndt Family chiropractic is authorized to release my medical records and/medical information to other physicians who will assist and/or will provide medical care to me, but who are not my primary treating physicians.
- I authorize Arndt Family Chiropractic to utilize my social security number when required for purpose of releasing information.
- I understand that if the authorized recipient is not a provider, health plan or clearing house required to comply with the federal standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed by the recipient without obtaining any further authorization.

Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Arndt Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Witness