ELITE SPINE AND SPORT CENTER

CHIROPRACTIC HEALTH QUESTIONNAIRE

Name:_____ SS#: _____ Today's Date: _____/_____/_____

Address:_____ City: _____

State: _____ Zip:_____

What you prefer to be called: _____ Age: _____ Birthdate: _____/_____/_____

Handedness: _____ Height: _____ Weight: _____ Number of Children: _____

☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail Address: _____

Occupation: _____ Employer: _____

Referred By: _____

The reason for this visit is a result of: ☐ work ☐ sports ☐auto ☐ trauma ☐ chronic

Explain what happened:_____

_____

Please describe the pain and its location: _____

_____

When did condition begin?_____/_____/_____ Have you had this or similar conditions in the past? ☐ Yes ☐ No

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine If so, please explain:_____

_____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No If so, where?_____

_____

Name and address of primary physician _____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If yes, please explain:_____

_____

Are you currently taking any medication? ☐ Muscle Relaxants ☐ Blood Thinners ☐ Insulin ☐ Stimulants
☐ Tranquilizers ☐ Pain Killers ☐ Other(s)_____

Have you ever had any of the following diseases or medical conditions?

☐ Arthritis	☐ Asthma	☐ Sinus Trouble	☐ Joint Replacement	☐ Allergies
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Thyroid Trouble	☐ High/Low BP
☐ Emphysema	☐ Ulcer / Colitis	☐ Cancer	☐ Polio	☐ Rheumatic Fever
☐ Emotional Disorders	☐ Bone Fracture	☐ Multiple Sclerosis	☐ Prostate Trouble	☐ Kidney Disease
☐ HIV +	☐ Heart Attack	☐ Stroke	☐ Hepatitis	☐ Anemia
☐ Neck Pain	☐ Low Back Pain	☐ Headaches	☐ STD's	☐ Joint Pain

Please list any other notable conditions that you had / have_____

Family history of any of the previous or other? ☐ Yes (please note_____) ☐ No

What are your habits?

Smoking	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Alcohol	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Recreational Drugs	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Exercise	☐ Never	☐ Occ	☐ Moderately	☐ Excessively

List any previous surgeries/hospitalizations and dates_____

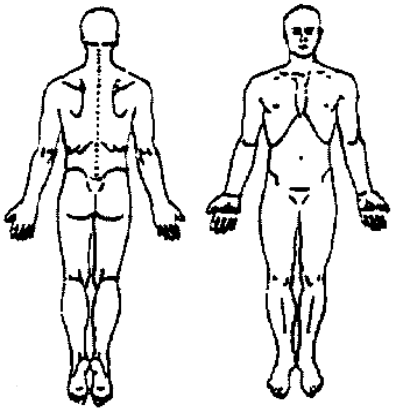
List any past serious accidents and dates_____

Are you wearing any: ☐ Heel lifts ☐ Inner soles ☐ Arch Supports What is the age of your mattress?_____

For Women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes (How many mo._____) ☐ No

Date of your last period?_____ Are you under the regular care of an OB/GYN? ☐ Yes ☐ No

Please mark the location of your pain on the following



Insurance Co. Name:_____

Address:_____

_____

ID#:_____ GRP#:_____

Insured's Name:_____

Relation:_____ DOB:_____

Insured's Employer: _____

Please inform front desk of any 2nd insurance source

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature_____ Date _____/_____/_____

Guardian or Spouse's Signature_____ Date _____/_____/_____

PATIENT CONSENT AND AUTHORIZATION

1. _____**HIPPA Patient Disclosure:** I understand that, by signing this consent form, I am granting my consent to Dr. Russell to use and disclose my protected health information to carry out treatment; payment activities and heath care operations. Our Notice of Privacy Practices provides more detailed information about the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. You have a legal right to review our full Notice. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice Privacy Practices, which will be available by contacting our office. Those changes may apply to any of your protected health information that we maintain. I acknowledge that I have had an opportunity to review the Notice of Privacy Practices.

2. _____**Assignment of Benefits:** I hereby authorize my insurance company to make payment of medical benefits to Elite Spine and Sport Center for medical services rendered to me. I also authorize the release of any medical or other information necessary to process this claim.

3. _____**Resolution of Disputes:** In the rare circumstances that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

4. _____**Medicare:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to Elite Spine and Sport Center.

5. _____ **(Female Patients Only) Verification of Non-Pregnancy:** By my initials on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

6. _____**Permission to Evaluate and Treat a Minor Child/Dependant Adult:** I authorize the office to evaluate and treat _____. (Relationship: _____)

Patient Name: _____

File #: _____

Date: _____

Patient Signature: _____

OFFICE FINANCIAL POLICY

Our policy requires payment at time of service unless specific arrangements have been made in advance. Our agreement is with you and not your insurance company. Although this Chiropractic Office will prepare any necessary reports and forms to assist you in making collection from the insurance company, and any amount authorized to be paid directly to this Chiropractic Office will be credited to your account upon receipt, you are financially responsible for the services you receive. Payment to our office is not contingent upon payment by your insurance company. You are considered a cash-paying patient until you provide completed insurance information and we verify and accept your insurance coverage.

HMO and PPO members will be expected to pay co-pays or deductibles at the time of service.

If you wish to file you own insurance claims we will provide you with the necessary itemized statements to file for reimbursement.

If you request that we file your insurance claims for you and if we agree to accept assignment from your insurance company, and if your carrier has not paid a claim within thirty (30) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

Should your responsibility for any account balance go unpaid past ninety (90) days despite repeated attempts to collect payment, your account may be turned over to an outside collection agency. In that case, you will assume the further responsibility of, but not limited to, collection fees, legal fees and interest on any balances due past ninety (90) days, if no acceptable arrangements have been made with the business manager.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

If you have pre-paid for any services and do not receive them or if you cancel any pre-paid services, you will receive a pro-rated refund following a complete resolution of any outstanding payments from your insurance company.

If a check is returned, there will be a $25.00 service fee charged.

I have read and understand my financial responsibilities under this financial policy.

Guarantor's Name:

Relationship:

Signature:

Date:

For your convenience, you may retain your credit/debit card on file with us.