

CASE HISTORY

Name: _____ Home (____) _____ Work (____) _____

Address: _____ City / Zip _____

Referred by: _____ Birthday: _____ Occupation: _____

Main Complaint: _____

How and when did this condition happen: _____

Have you had this or similar condition in the past? (Yes) (No) When? _____ Getting worse? (Yes) (No) (Constant)

List any other complaints: _____

List surgical operations and year: _____

List present medications: _____

List Allergies: _____

Results you would like to obtain at this office: _____

Other Practitioners seen: (MD) (DC) (DO) (Therapist) (Acupuncturist) (Homeopathic) (Naturopath) (Kinesiologist) (Health Consultant) (other)

Doctor s name: _____ Doctor s name: _____

Address or phone: _____ Address or phone: _____

Diagnosis Offered: _____ Diagnosis Offered: _____

Treatment Results: _____ Treatment Results: _____

Would you like me to discuss you care with another physician listed above? (yes) (no) (I ll'decide later).

I understand and agree that all services rendered are charged directly to me and that I am responsible for payment. I also understand that payment for these services are due at the time of service. A statement will be provided when requested and we will mail a statement to your insurance carrier if we have completed information.

Signature _____ Date: _____

We welcome email communication to request a billing statement, questions about your care or office policy. If you provide us with your email, it will remain private and any group email communication will be by blind copy only.

Please circle if okay to include my email address in future correspondence; ..(Office visit remainders)

(Follow-up / preventative visit remainders) (Future sporadic newsletters). (Use for doctor - patient correspondence only).

Email Address: _____ (optional).

It is the goal of this office to provide integrative alternative health care in a cost effective and efficient manner. To accomplish this, we utilize minimal staff and ancillary services. If you miss an appointment or fail to give us appropriate cancellation notice, there will be a fee. It is your responsibility to call and reschedule as well as schedule preventative /follow up visit(s) commonly every 6 months.

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Insurance Information

The following insurance information is required to process your benefits claim. Incomplete information will necessitate us mailing the form back to you before it can be processed. If this Insurance information relates to a Motor Vehicle Accident or Work Injury, please do not fill in this form and request an additional Accident Form.

Insurance Company Name & Address: _____

City / State / Zip: _____

Insured Name [if other than yourself]: _____ Claims Person if known: _____

Soc. Sec.# of Insured: _____ Group #: _____

Has a claim for this illness or injury been previously submitted by another health care provider? (yes) (no)

Name of Provider: _____ (optional)

If your insurance has restrictions in coverage please list below. If you are aware of any therapy procedural restrictions please also list below.

Insurance benefits coverage can vary significantly from policy to policy. The reimbursement rate for chiropractic care is often predetermined and or preset at a usual and customary service value for this area. The benefits value can range from \$25 to 100% coverage. We have seen an average reimbursement rate of approximately \$55 for our general office visit however all carriers are different and again, it will vary by the type of policy you have. Most general blue cross policies have a fixed reimbursement rate of \$25.

Authorization for Care of a Minor

I hereby authorize care to be administered as deemed necessary to my child. Additionally I recognize that I will have ongoing opportunity to discuss any concern before during or after any therapy provided. Email correspondence is welcome.

Parent or guardian _____ Date: _____

Medicare Coverage

If you have Medicare coverage and it is not assigned to another provider, all necessary forms will completed for you to be reimbursed at an of approximately governmental authorized value of \$27 a visit. Please note that if you have additional coverage it will be automatically forward by Medicare to your secondary provider. By my signature below, I fully understand that this provider is not accepting Medicare s'~ \$27 assignment of benefits and I that I am responsible for the full office visit fee.

Signature: _____ Date: _____

If you are requesting care for injuries sustained in a motor vehicle accident, personal injury, or work injury, please request a separate form to complete. We will need additional information about the date and location of your accident, prior care if any, and insurance or attorney information.

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