Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

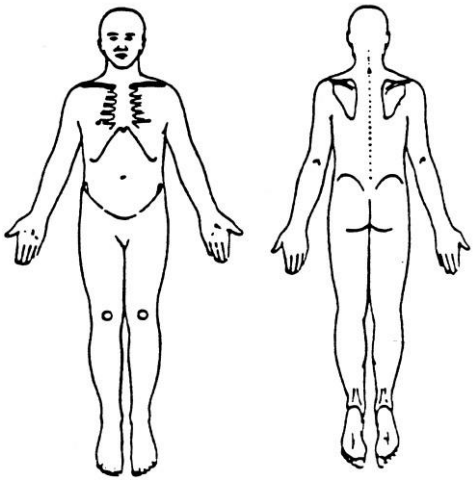
Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

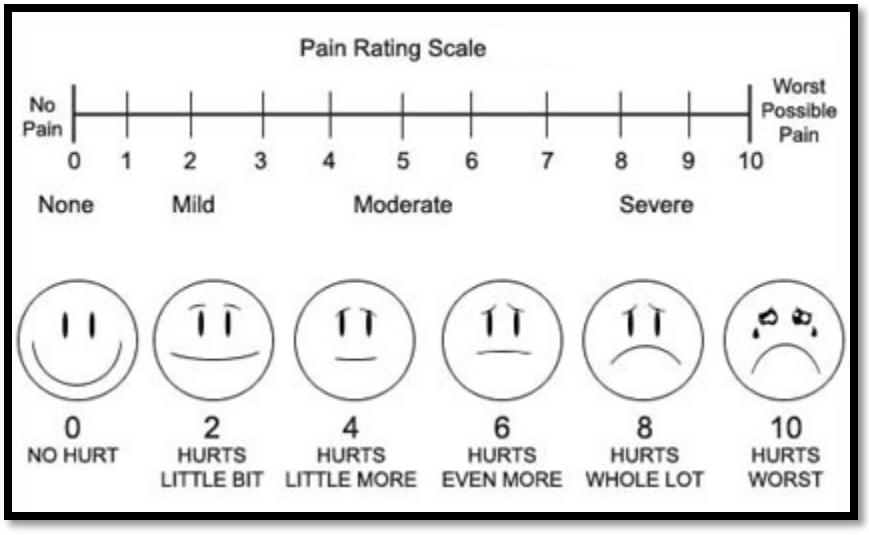
WELCOME TO
OUR OFFICE

Atlas Family Chiropractic · 1255 Boyson Loop Hiawatha, IA 52233·
Phone: 319-393-7744 · Fax: 319-393-1035

PATIENT INFORMATION	**DATE** / /
Employer:	**INSURANCE INFORMATION**
Employer Address:	Please present your insurance cards and photo ID.
City/State/Zip:	Policy Holder Name:
Occupation:	Birthdate: / / Self □Spouse □Child/Dep.
Work Phone:	
EMERGENCY CONTACT	**REFERRAL** How did you find our office?
Relation and Name:_____	Phonebook □Insurance □Internet □Location □Mailing
Contact Phone:	□Sign □Patient, their name? _____
RESPONSIBLE PARTY- If you are younger than 18.	**ACCIDENT INFORMATION**
Name:	Is condition result of an accident? YES NO
Relation: Phone:	If Yes (Work, Auto) please ask for additional forms.
PATIENT HISTORY	**PAST HISTORY**
Where is your pain?	Have you had any fractured bones? □YES □NO
	Where? When?
Mark any symptoms that you currently have:	Have you ever been hospitalized? □YES□NO
□Headaches □Nausea □Difficulty walking	Are you pregnant? □YES □NO
□Neck pain □Upper back pain □ Joint pain	Do you have abnormal menstrual problems? □YES □NO
□Jaw pain □Low back pain □ Stiffness	List ALL past surgeries or procedures and approx. year:
□Shoulder pain □Leg pain □ Muscle spasms	
FAMILY HISTORY- Parents and siblings only.	Mark any diseases you have had below.
□Cancer □Clotting Disorder □Dementia	□Anemia □Heart Disease □Arthritis □Pneumonia
□Diabetes □Gastrointestinal □Heart Disease	□Measles □Mumps □Epilepsy □Influenza
□High Cholesterol □Hypertension □Kidney Disease	□Mental disorder □Diabetes □Rheumatic fever
□Lung Disease □Osteoporosis □Psychological Disorder	□Eczema □Whooping Cough □Cancer □Alcoholism
□Septicemia □Stroke □Sudden Infant Death Syndrome	□Tuberculosis □AIDS/HIV □Venereal Disease
Description:	
	MEDICAL DOCTOR NAME:

Indicate areas of pain on the diagram below





IF NO INSURANCE: Payment is due when treatment is given.

INSURANCE: Deductibles, co-payments, and non-covered services are expected to be paid at the time of service or on the 15th of each month (or the following Monday if the 15th falls on a weekend) via card on file. If you discontinue treatment, any charges are immediately due and payable. It is your responsibility to provide us with the correct insurance card, insurance benefits, and update us of ANY changes. If correct insurance and/or insurance benefits are not provided, you are responsible for all charges denied by insurance, including but not limited to, due to timely filing, being out-of-network, or surpassing your limit for chiropractic visits.

PAYMENT: I understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Linn County. I authorize Atlas Family Chiropractic to charge my card on file for any outstanding balance on the 15th of each month (or the following Monday if the 15th falls on a weekend). I understand that if I wish to receive paper statements, I will incur a $3.00 fee per statement sent. If I wish to set up a payment plan, I must call before the 15th of the month. If I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections (a minimum finance fee of $30.00). All portions of any bill sent to me by Atlas Family Chiropractic shall be assumed valid unless disputed in writing within thirty (30) days of receiving the bill.

TREATMENT PERMISSION: I authorize Atlas Family Chiropractic to render chiropractic treatment/care.

ASSIGNMENT OF RIGHT TO PAYMENT/LIEN AGAINST BENEFITS: I authorize Atlas Family Chiropractic to file my insurance claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Atlas Family Chiropractic. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements or recoveries, and to adequately protect and to make payment for these services directly to Atlas Family Chiropractic pursuant to this assignment and lien.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize Atlas Family Chiropractic to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices.

CANCELLATION/NO SHOW POLICY: We understand that there are times when you must miss an appointment due to illness, emergencies, or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **Any appointment that you no show or cancel same-day will incur a $30.00 fee**; this will not be covered by your insurance company.

IF LATE FOR AN APPOINTMENT: Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This may be an inconvenience to others. We strive to see every patient as close to their appointment time as possible.

AUTHORIZATION: By signing below I am agreeing to the terms listed above as well as giving my permission and consent for treatment given by Atlas Family Chiropractic.

PRINT NAME:_____ **SIGNATURE:**_____ **Date**_____

Atlas Family Chiropractic

Policy Agreement & Authorization Form

PLEASE READ CAREFULLY. INITIAL EACH ITEM AND SIGN AND DATE AT THE BOTTOM INDICATING YOUR AGREEMENT

Authorization to Keep Card on File

_____ I authorize Atlas Family Chiropractic to keep a credit or debit card on file for my account. I acknowledge it is my responsibility to update a card on file if it should expire.

Authorization to Charge Card on File

_____ I authorize Atlas Family Chiropractic to charge any self-pay services (without insurance) and copays to my card on file AT TIME OF SERVICE.

_____ I authorize Atlas Family Chiropractic to charge my card on file for any remaining unpaid balance on my account or the accounts of my dependents on the 15th of each month. If the 15th should fall on a weekend, my card will be charged on the following Monday.

_____ I authorize Atlas Family Chiropractic to keep a valid email address on file to email a receipt or proof of payment each time my card is charged.

_____ I acknowledge that it is my responsibility to contact Atlas Family Chiropractic prior to the 15th if I should wish to arrange a payment plan.

Acknowledgement of Fees & Collections

_____ I acknowledge that I will receive a paper statement in the mail if I do not authorize to keep a card on file AND I have any remaining unpaid balance on my account by the 15th of the month, and that my account will incur a fee of $3.00 for each statement sent. If the 15th should fall on a weekend, this applies to the following Monday.

_____ I acknowledge that I will receive a paper statement in the mail if I do not update an expired card on file OR if my card on file has insufficient funds to cover the balance on my account when it is ran on the 15th of the month, and that my account will incur a fee of $3.00 for each statement sent. If the 15th should fall on a weekend, this applies to the following Monday.

_____ I acknowledge that my account may incur additional fees, a minimum of $30.00, and be sent to collections if my balance becomes past due.

_____ I acknowledge that there is a $35.00 fee per returned/bounced check.

CONTINUED ON THE NEXT PAGE

Acknowledgement of Responsibility to Update Demographics

_____ I acknowledge that it is my responsibility to inform Atlas Family Chiropractic of any changes to my mailing address, phone number, or email address. By writing my information below, I am indicating that it is current at the time of filling out this form (DATE ON LAST PAGE).

ADDRESS → _____

PHONE → _____

EMAIL → _____

_____ I acknowledge that my account may incur additional fees equivalent to the cost of statement mailing and postage, $3.00 for each statement sent, if an attempt is made to mail a statement to an outdated mailing address.

Acknowledgement of Responsibility to Provide Correct Insurance & Insurance Benefits

_____ I acknowledge that it is my responsibility to inform Atlas Family Chiropractic of the insurance that I have active coverage for at the time of service. I acknowledge that if I provide the wrong insurance, I am responsible for any charges denied by insurance, including denial due to timely filing.

_____ I acknowledge that it is my responsibility to know and provide Atlas Family Chiropractic my correct insurance benefits, including but not limited to, in-network status, copay, and visit limits. I acknowledge that I am responsible for any charges denied by insurance, including being out-of-network or surpassing my limit for chiropractic visits.

Acknowledgement of Responsibility for Non-Covered Services

I acknowledge that I am responsible for any services not covered by insurance, including but not limited to, exams, x-rays, or if I have surpassed my limit for chiropractic visits.

_____ Atlas Family Chiropractic is aware that these insurances do not cover:

Medicare: Does not cover exams (including re-exams) and x-rays
Medicaid: Does not cover exams (including re-exams)
UnitedHealthcare and UMR: Does not cover x-rays
TriCare: Does not cover ANY chiropractic services

_____ I acknowledge that payment is due AT TIME OF SERVICE for the above non-covered services.

CONTINUED ON THE NEXT PAGE

Acknowledgement of Motor Vehicle Accident or Workers' Compensation Case Responsibility

_____ I acknowledge that I am responsible for any charges related to a motor vehicle accident or workers' compensation that remain unpaid after 90 days from the first date of service, including in cases where my medical insurance has been billed but refuses to pay.

Acknowledgement of No Show & Cancellation Policy

_____ I acknowledge that it is ultimately my responsibility to keep track of my scheduled appointments, and that my account will incur a $30.00 charge for any appointments missed or forgotten. I acknowledge that text or email appointment reminders from Atlas Family Chiropractic are a courtesy, and are not to be solely relied on.

_____ I acknowledge that my account will incur a $30.00 charge for any appointments cancelled with same-day notice. I acknowledge that if I need to cancel an appointment, I may call or leave a voicemail up to the day before my appointment, even if it is on the weekend or after business hours, and the cancellation fee will be waived.

PLEASE SIGN, PRINT, AND DATE BELOW TO INDICATE YOUR AGREEMENT WITH THESE TERMS FOR ATLAS FAMILY CHIROPRACTIC

_____

↑ SIGNATURE ↑

_____

↑ PRINT NAME ↑

_____

↑ DATE ↑

_____

↑ PLEASE LIST ANY MINOR CHILDREN/DEPENDENTS THIS AGREEMENT IS ALSO VALID FOR ↑

This form remains valid indefinitely and does not have an expiration date.
It may only be re-signed if there is an update or addition to these policies.