"Your Health is Our Main Concern"

PT. #_______________

Date:__________________

Name	Nickname	Social Security No.

Address & Street	Sex ☐ Male ☐ Female

City, State, Zip	Phone	Date of Birth	Age

☐ Married ☐ Widow ☐ Single ☐ Divorced	Health Ins. - ☐ Yes ☐ No	Primary ____________ Secondary ____________	Subscriber Name	Subscriber Date of Birth

Subscriber Address	Subscriber Phone

No. of Children	Ages	Cell Phone:	E-mail address

Occupation	Employer	Work Phone No. ( )

Is your visit prompted by any specific complaints. Explain:	Preferred contact ☐ work ☐ home ☐ cell

Emergency Contact	Relationship	Phone ( )

Referred by	Have you had chiropractic care before? ☐ Yes Where? ☐ No	Do you have health insurance? ☐ Yes Primary Company____________ ☐ No Secondary Ins. ____________

Please indicate if you are here for care because of: ☐ an on the job injury ☐ an auto accident

Have you ever had any falls, accidents or injuries? ☐ Yes If needed use ☐ No space below	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
Have you ever had surgery? ☐ Yes If needed use ☐ No space below	**MONTH, YEAR**	**TYPE OF SURGERY**	**COMMENTS**

Are you presently taking medication? ☐ Yes If needed use ☐ No space below	NAME OF DRUG	DOSES PER DAY	NAME OF DRUG	DOSES PER DAY

Is it possible you are pregnant? ☐ Yes ☐ No	Prior Illnesses?

Please check any of the following that give you difficulty. ☑

☐ Headaches	☐ Fainting	☐ Shortness of breath	☐ Ulcers
☐ Shooting head pains	☐ Loss of balance	☐ Mid-back pain	☐ Numbness in legs or feet
☐ Sinus trouble	☐ Ringing in ears	☐ Heart attacks	☐ Constipation
☐ Loss of smell	☐ Blurred Vision	☐ High blood pressure	☐ Kidney trouble
☐ Allergies	☐ Lights bother eyes	☐ Low blood pressure	☐ Menstrual cramps and pain
☐ Hayfever	☐ Neck pain	☐ Anemia	☐ Menstrual irregularity
☐ Asthma	☐ Muscle spasms in neck	☐ Stomach trouble	☐ Diabetes
☐ Loss of Taste	☐ Grinding in neck	☐ Nerves and nervousness	☐ Cancer
☐ Inflammation of throat	☐ Tightness of shoulders and arms	☐ Inner tension	☐ Sleeping problems
☐ Thyroid trouble	☐ Pain in shoulders and arms	☐ Irritability	☐ Painful joints
☐ Twitching of face	☐ Pins and needles in arms & hands	☐ Gall bladder trouble	☐ Swollen joints
☐ Loss of memory	☐ Ear ache	☐ Indigestion	☐ Pins and needles in legs
☐ Fatigue	☐ Numbness in arms / hands	☐ Intestinal gas	☐ Swollen ankles
☐ Depression	☐ Cold hands / fingers	☐ Low back pain	☐ Cold feet
☐ Dizziness			☐ Pains in legs and feet

Please indicate which activities of daily living are affected by your present complaints

General	☐ Walking	☐ Sleeping	☐ Playing piano	☐ Using keyboard
	☐ Sitting	☐ Standing	☐ Using a telephone	☐ Exercising
	☐ Climbing Stairs	☐ Lifting children	☐ Running	☐ Sitting in recliner
	☐ Chewing	☐ Reading	☐ Bending	☐ Getting into/out of an automobile
	☐ Kneeling	☐ Swimming	☐ Lying in bed	
Housework	☐ Doing Laundry	☐ Vacuuming	☐ Ironing	☐ Caring for pets
	☐ Making beds	☐ Washing dishes	☐ Carrying groceries	☐ Cooking
Yardwork	☐ Mowing Lawn	☐ Raking leaves	☐ Gardening	☐ __________________
Personal Grooming	☐ Combing hair	☐ Shaving	☐ In/out bathtub	☐ Brushing teeth
Travel	☐ Driving a car	☐ Riding in a car	☐ __________________	☐ __________________

NOTE: It is understood and agreed the amount paid Correct Care Chiropractic for x-rays is for examination only and the x-ray negatives will remain in the property of this office, being on file where they may be seen while a patient of this office.

Signature:____ Date:___________________________________

To avoid bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

Doctor's Use Only

P.O.P. / P.D. / P.S. (F.A.) / F.T. / L.O.T. / D.O.C. / H.P. / A.E.P. / N.L.W.

COMMENTS ____
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SECONDARY COMPLAINT ____
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A- 5/6/4 B- 3/5/4 C- 2/5/4 1/5/4 -C 0/2/5 -C _____________OTHER

Insurance and Payment Policies

At Correct Care, we offer full-service billing. This means that, upon verification of benefits from your insurance carrier, we will bill any applicable services directly to them. All co-pays and payment for services not covered under your policy are due at the time of service. If, as in the case of Blue Cross Master Medical, you will be receiving reimbursement checks at home, you will be required to pay for services at the time of your visit.

It is your responsibility to know and understand your insurance coverage. Since we are not party to your agreement with your insurance carrier, we are not able to resolve payment disputes with them on your behalf. We ask that you contact your carrier directly with any reimbursement questions. Again, you will be personally responsible for any unpaid balances, which are due upon receipt of your statement.

If you plan requires that you receive a referral from your primary care physician, please have that ready before you make your appointment.

If you have been involved in an auto accident or work-related incident, please let us know prior to treatment. In these cases, we will need additional documentation and insurance information. This will help us in our billing process and protect your rights under the law.

Patients without insurance coverage are expected to pay at the time of service. If you are having difficulty paying for your care, please let us know. We have many payment options designed to make chiropractic care affordable for everyone.

Correct Care reserves the right to deny service for lack of payment. A service charge will be applied to all balances over 30 days at the rate of $10 per month. Account over 90 days will be placed in collection. Patients are responsible for any and all collection costs.

Please sign your name below indicating that you have read the above and understand it.

______________________________	______________________________
Patient Name	Patient Signature
______________________________	______________________________
Date	Witness

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Correct Care Chiropractic and hereby release you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to Correct Care Chiropractic any monies due them on account, the same to be deducted from any settlement made on my behalf. Further, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

ACKNOWLEDGEMENT OF PROTECTED HEALTH INFORMATION PRACTICES: It is understood that by Federal Law, this patient's personal health information is protected. This office has available for review its Health Privacy Policy regarding the sharing of that information. Should I have any questions regarding this policy, I will contact this office.

TERMS OF ACCEPTANCE: It is understood that the chiropractic care received in this office is not meant to diagnose or treat any disease or condition other than vertebral subluxation.

CONSENT TO CARE FOR A MINOR: I hereby authorize Correct Care Chiropractic to administer care as deemed necessary to: ___________________________Relationship:_____________D.O.B_________

ACKNOWLEDGEMENT OF SPECIAL PROMOTIONAL FEE: I acknowledge that this 1st visit maximum out-of-pocket discount coupon, referral card, etc.(______________) is a special promotion at Correct Care Chiropractic regardless of any insurance deductible or copays due to our office. I understand that my health insurance will be billed the full fees for these services. I expect to receive no further notice of this policy.

ACKNOWLEDGEMENT OF X-RAY FEES: It is understood and agreed the amount paid to Correct Care Chiropractic for x-rays is for examination & interpretation only. As a courtesy, a copy of the digital x-rays will be provided when the doctor reviews them with me. I understand that there is a copy charge for any additional x-ray copies.

_______________________________ _______________________________

Patient Name Patient Signature

_______________________________ _______________________________

Date Signed Witness