WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

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 _____

Birthdate _____ 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 (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work 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 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) _____

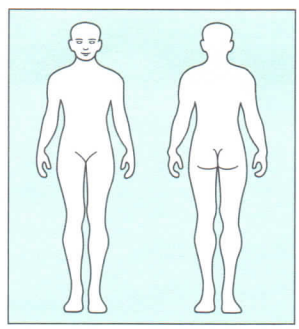
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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 _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

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

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

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (_____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS

Active Family Chiropractic

Patient Information & Financial Policy

Thank you for choosing Active Family Chiropractic, LLC as your chiropractic and musculoskeletal care provider. It is our goal to meet our patients' needs and address all concerns effectively. We encourage yourself, family members, and spouse to ask questions regarding your health. An area of primary concern for all patients is the financial policies of the practice, especially those pertaining to insurance billing and payment requirements. Remember **INITIAL CONSULTATIONS ARE ALWAYS FREE.**

PAYMENT: Patients who have an insurance carrier with whom the practice has a valid contract will be responsible for all fees as outlined in the patient's contract agreement. All Co-payments, Co-insurances, and deductable amounts are due at the time of service as outlined in your insurance policy. Any denied services by the insurance company will ultimately become your responsibility. Patients without insurance coverage, or choose to not use their insurance are responsible for payment in full at the time of service.

REFERALLS ARE THE PATIENT'S RESPONSIBILITY!! If you do not have your referral at the time of your visit, you will be financially responsible for the charges incurred from care. Claims are **ONLY** filed for the insurance companies whom we have contracted with to be a participating provider.

Returned checks will result I a $35 service charge.

Statement & Billing Correspondence: are sent to update the patient as to the status of the account and whether your insurance has fulfilled their obligation to you to pay claims in a timely manner.

Delinquent Accounts are placed for collection 120 days from the date the service was provided. Patients having financial difficulties are encouraged to talk with our Office Manager before the account becomes delinquent and any interest is applied.

Insurance Only: I, the undersigned, certify that I or my dependents have insurance coverage, and assign directly to Active Family Chiropractic, LLC / Dr. Barry Hazen, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____ **Authorization for Release of Information (Needed for HIPAA)**

I, _____authorize by my signature below the use or disclosure of my individual health information to the following Organization(s) or Person(s):_____

_____. Purpose of this disclosure is typically for Insurance companies, correspondence to referring physicians and/or other health care providers, attorneys, and copy companies in relation to injury cases. This authorization at anytime can be canceled by written notification to Active Family Chiropractic, LLC. If there is any information you wish not to be disclosed please indicate the nature of that below, otherwise it will be noted that all individual health information may be disclosed:

_____

Signature: _____ Date: _____

HIPAA: A copy of the offices' HIPAA policy is available upon request. I understand that my records are kept confidential by this office, unless my signature is obtained for release of my or my dependents records.

Initials: _____

Active Family Chiropractic

Patient Information & Financial Policy

Financial Policy: Your understanding of our financial policies is an essential element of your care and treatment. If you have any concerns, please discuss them with the Office Manager at the appointment.

1. As the Patient or Guarantor, you are responsible for all charges incurred.
2. If you do not have insurance coverage, payment in full is expected at the time of service.
3. Although we estimate your insurance benefits, we are NOT responsible for their accuracy.
4. We expect payment for your estimated portion of the balance at the time of service.
5. We accept assignment of benefits with some major medical plans. We will bill those plans and require you to pay the co-pay or deductible at the time of service.
6. If your plan does not assign benefits (out of network) to our practice, you will be required to pay the balance in full at the time of the visit.
7. Past due accounts are subject to a 1.5% interest charge per month from the date of service and may be sent to collections. All fees's, including but not limited to the collection fees are your responsibility in addition to the balance due to our office.
8. Payment plans are available at your request.

Your initials below indicate that you:

1. Have read and understand the above information.
2. Authorize and request payment under your medical insurance to be made to Active Family Chiropractic, LLC. (Dr. Barry Hazen)
3. Accept financial responsibility for all fees incurred for services & products provided regardless of your insurance coverage.
4. Permit a copy of this authorization to be used in place of the original.
5. Records releases: Must submit in writing a request, will take 24-72 hours, cost $35.

Intials:_____ Date:_____

Appointment Policy: You must notify the office as soon as possible (24 hours notice is appreciated) in advance to cancel an appointment. We will try to reschedule your appointment in such a manner that it will not affect the outcome of care. With chiropractic care, physical therapy, and even personnel training (going to the gym) the FREQUENCY of treatment is extremely important. Making up missed appointments within 7 days is obligated.

1. No show/ Cancellation policy- if you cancel or no-show for an appointment with less than 24 hours of notice, you will be charged $40.
2. Repeated broken appointments and short notice cancellation may be subject to dismissal from the practice.
3. IF you are more than 15 minutes late, without prior notice (just call us) your appointment may need to be cancelled or re-scheduled.
4. School excuses are provided for children whose appointments must be scheduled during school hours.
5. Missed appointment may be viewed as non-compliance by you in whom they could deny payment for services rendered. Therefore please follow the treatment plan as prescribed.
6. As a courtesy, we will set up an appointment reminder in our system such that you can either get an automated message reminding you either by e-mail, text, or phone.
   Your signature below indicates your understanding and acceptance of our appointment policy.

Initals:_____ Date:_____

I have read the financial policy of Active Family Chiropractic, LLC and understand and agree to adhere to the policies as outlined. I understand that I am responsible to pay my financial obligation in full by the date specified by the office. If for some reason I do not pay the balance in full, I will be held accountable for any and all late fee's collection fee's, interest, or finance charges, etc. that may accrue.

_____

Signature of responsible party /Guarantor Date

Active Family Chiropractic

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and any potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by Dr. Barry Hazen, or by other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for Dr. Hazen.

I have had the opportunity to discuss with the Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risk and benefits of my chiropractic treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/Strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain
- No improvement of symptoms or pain
- Bruising (physical therapy)
- Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement.), and death.

I do not expect the doctor to be able to anticipate and explain all the risk and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment.

To be completed by the patient:

Print name: _____

Signature of patient: _____

Date signed: _____

To be completed by the patient's representative:

Print name of patient: _____

Print name of patient's representative _____

Signature of patient's representative _____

Relationship/authority of patient's representative: _____

Date signed _____

To be completed by doctor or staff:

Witness to patient's signature _____ Date _____

Translated by _____ Date _____

April 2016