KOVACS

CHIROPRACTIC & NUTRITION CENTER

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____

❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. ❑Male ❑Female

Your email will NOT be shared with any 3d parties, and is used for monthly newsletters articles and also health education seminar dates.

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ (cell) _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Employer_____ Occupation _____ Work PH_____

Marital Status ❑Married ❑Single ❑Divorced ❑Widow

Spouse's name _____ Spouse's Occupation _____Spouse's employer _____

Emergency contact _____ Phone _____

Referred By ❑Shopper ❑Word of Mouth ❑Patient ❑Drive By ❑Walk In ❑Website ❑Massage Therapist ❑Dr. ❑Other _____

Current Complaints

Date of onset _____ Is this due to an automobile accident* ❑ Yes ❑ No

Please describe _____

_____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? ❑ No ❑ Yes If yes, when? _____

List other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? ❑ No ❑ Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ❑ No ❑ Yes Name of company _____

* If an auto accident please provide:

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ❑ No ❑ Yes

If yes, please describe _____

Date of last physical exam _____. Is there a chance that you are pregnant? ❑ No ❑ Yes

Have you had X-rays taken? ❑ No ❑ Yes If yes, where? _____

What **medications** are you taking and for what conditions (Please list dosage and amounts, etc).

_____

_____

_____

What **vitamins, minerals, or herbs** do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	_____
Been hospitalized?	❑	❑	_____
Been in an auto accident?	❑	❑	_____
Had Sprains/Strains?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had surgery?	❑	❑	_____

Family History	
Family Member	**Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

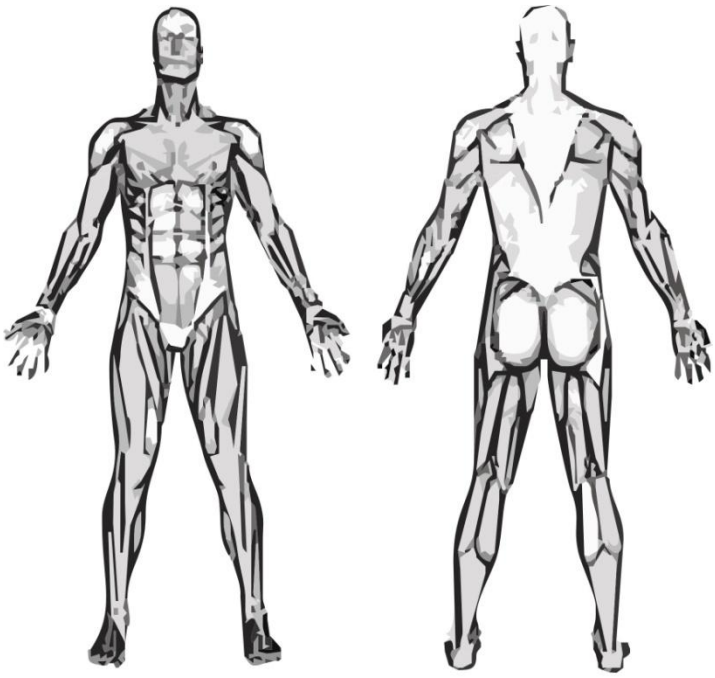
Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑

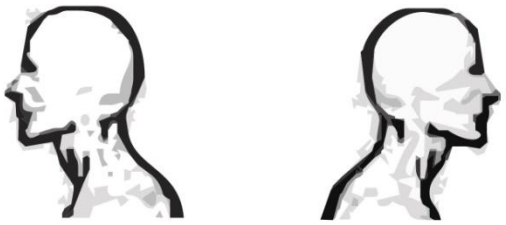
Have you ever suffered from:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain/Conditions
- ❑ Cold extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Ears Ring
- ❑ Excessive Menstruation
- ❑ Eye Pain/Difficulties
- ❑ Fatigue
- ❑ Frequent Urination
- ❑ Headache
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Irregular Cycle
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Loss of memory Loss of balance
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Lumps In Breast
- ❑ Neck Pain or Stiffness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Sciatica
- ❑ Shortness of breath
- ❑ Sinus Infection
- ❑ Sleep problems/insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Swollen Joints
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing





Do you experience pain every day?	❑ No ❑ Yes
Do your symptoms interfere with daily life?	❑ No ❑ Yes
Does pain wake you up at night?	❑ No ❑ Yes
Are your symptoms worse during certain times of the day?	❑ No ❑ Yes
Do changes in weather affect your symptoms?	❑ No ❑ Yes
Do you wear orthotics?	❑ No ❑ Yes
Do you take vitamin supplements?	❑ No ❑ Yes
What activities aggravate your symptoms?	❑ No ❑ Yes
_____	
_____	
_____	

What goals and expectations do you have?

- ❑ Relief from pain and symptoms
- ❑ Chiropractic wellness care
- ❑ Nutritional and herbal support
- ❑ Diet and lifestyle improvement
- ❑ Weight management
- ❑ Detox and purification
- ❑ Relief from allergies
- ❑ Other: _____

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Parent/Signature: _____ Date: _____

KOVACS

CHIROPRACTIC & NUTRITION CENTER

OFFICE POLICY

Welcome to Kovacs Chiropractic & Nutrition Center. Dr. Kovacs and his staff are dedicated to providing you with the finest in chiropractic and nutritional health care! Please take a moment to acquaint yourself with our office policies. Our policies are designed to enhance your doctor patient relationship.

NEW PATIENTS: **All new patients to our clinic will have a new patient exam.** Your first appointment will consist of an exam and an adjustment. If going through insurance, you will be charged for the new patient exam and any adjustment procedures that were done during the first appointment. If you are self-pay, the fee of the **new patient exam** and the adjustment procedure will be due at time of service. Any additional appointments will consist only of adjustments to specific regions of the body.

ALL MEDICARE PATIENTS: **Medicare and most secondary insurances do not pay for New Patient Exam procedures.** Although we will bill the exam through your insurance company, Medicare will not pay for the **new patient exam**. The **new patient exam** will be billed to you for the first appointment you had in our office. It may be 30-60 days before this gets processed through your insurance and you receive a bill. Medicare does however cover the actual adjustments or chiropractic treatments you will receive.

INSURANCE PATIENTS: **Co-pays are due at time of service.** We are providers for Blue Cross Blue Shield and Medicare. You will receive a bill only after everything has been submitted and we have heard back from your insurance company.

Our billing service is Compu-Med out of West Fargo and handles all our insurance submittals and statements for our patients.

PLEASE DIRECT ALL INSURANCE RELATED INQUIRIES TO COMPU-MED BILLING SERVICES,
PHONE: 1-877-848-3757.

Patient acknowledges that insurance coverage verification which is obtained from insurance carriers by this facility is not a guarantee of benefits and that benefits are determined as claims are processed. If we are unable to obtain reliable information from your carrier, we cannot take assignment on your insurance; however, we will be happy to provide itemized bills. You must understand and agree that health insurance policies are an agreement between the insurance carrier and yourself**.**

NUTRITION PATIENTS: All nutrition patients are required to pre-pay their first nutritional evaluation appointment fee of $100.00 at the time the appointment is scheduled. If you need to cancel or re-schedule this appointment, **the $100.00 is non-refundable.** Any follow-up nutrition appointments will require a 24 hour notice if you need to cancel or re-schedule.

FINANCIAL POLICY: Payment for care is due at the time of service for all co-pays, chiropractic treatments, exams, nutritional evaluations, consultations, and nutritional supplements. Cash, checks, Visa, and MasterCard are accepted.

If you are an insurance patient and are billed a total of three statements for services rendered and we have not heard from you at all for payment, we have no option other than to turn the account over to collections. If any payments are made during the 90 days, the collection will not happen. Only if you ignore 3 statements in a row with no payment effort will you be turned over to collections.

If your account balance at any time exceeds $200.00 for 60 consecutive days, you will not be seen until the balance is paid down below the $200.00 amount (including any visits at that time).

APPOINTMENTS: For your convenience, patients are seen on an appointment basis. We respect that your time is valuable too! Kindly give 24 hours advance notice, when possible if you must reschedule or cancel an appointment. Leaving a message is acceptable.

Should our facility need to contact you regarding appointment times or treatment, we will do so by calling the contact numbers you have provided. If necessary, a voice message will be left at these locations unless you provide written instructions otherwise.

LATE PATIENTS: If you come in after your appointment time you may have to be re-scheduled or have to wait for an opening depending on the type of appointment you had scheduled.

WALK INS: We do our best to accommodate those in acute pain. Please do not abuse this service.

CHILDREN AS PATIENTS: Parents are expected to accompany children during examination. No child will be treated unless parents have signed and authorized treatment for their child.

PLEASE DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING IT

I have read and acknowledge the office policies of Kovacs Chiropractic & Nutrition Center:

SIGNATURE_____DATE_____
CHILDS NAME (PRINTED)_____DATE_____
PARENTAL SIGNATURE _____DATE_____

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Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. The law requires us to give you this Disclosure, please realize that we have, and always will respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health care information as follows:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information to another party if they are responsible for payment of services.
- We may need to use your health information for operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be closed or used or disclosed. You have the right to review that notice before you sign the consent form (164.520). We reserve the right to change our privacy practices as described in the notice. If we change our practices we will notify you in writing or when you come in for treatment.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals companies, or organizations. If you would like to place any restrictions on your health records please notify us in writing. We are not required to agree to your restrictions, however if we agree with your restrictions the restrictions are binding to our clinic.

Your right to revoke your authorization

You may revoke your consent to us at any time; however the revocation must be in writing. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest your claims.
I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of the notice.

_____ _____ _____

Printed Name Signature Date

No Copy Necessary _____

Initials

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