Patient Registration Information

Name ____
Address ______________________Home Phone #___________
City_________________________ State________ Zip_________
Date______________ Social Security #_____________________
Sex _____ Date of Birth __________ Marital Status__________
Place of Employment____________________________________
Address of Employment__________________________________
Job Title_________________ Work phone #__________________
In case of an emergency who should we notify?______________
____
How did you learn about our office?________________________

Accident Information

Date of Accident____
How did the accident occur?________________________________
Who has been notified about this accident?___________________
____
Have you retained an attorney at law? Yes / No
Name of the attorney ____________________________________
Address ____
Phone #____

Patient Health History

What is your complaint today?______________________________
____
When did this condition begin? ____________________________
Grade the level of your pain from 1-10 with 1 being the least painful and 10 being the most painful.________________________
How frequent is the pain you are experiencing?________________
Have you received any treatment for this condition? Yes / No
What type of treatment? __________________________________

Please list the names of any health care practitioners you have seen for this condition in the spaces below:

____
____
____

Do you currently have any health related conditions that our office should be aware of that might be important for us to know about?

____
____
____
____

Have you had any health related conditions, in the past, that our office should be aware of that might be important for us to know about?____

____
____
____

Please list below any surgical procedures or operations that have been performed on you and please list applicable dates for each individual surgery.____

____
____
____
____

Please check any of the following activities that you regularly take part in:
Daily Exercise ( )   Smoking ( ) Consumption of alcohol ( )
Recreational Drugs ( ) Caffeine Products ( )

Please list below any medications that you are actively taking and the reason you are taking such medications.___________________

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Patient Signature________________________ Date_____________
Legal Guardian's
Signature_________________________________Date__________

Insurance Information

Name of Insured____
How are they related to the patient?_________________________
Insurance Company _______________________________________
Policy#________________ Deductible Amount ______________
Subscriber's Name ______________________ D.O.B.__________
Insurance ID#____

Direct Payment to Doctor / Release of Records: I state that I have insurance with _______________________ and assign to this office all allowable insurance benefits payable to me for chiropractic services rendered to me (or my dependant). I further understand that regardless of coverage I am ultimately responsible for any charges incurred at this office. I hereby authorize Dr. Daniel W. Talley B.S.D.C. to release all health information in my file to any insurance company or adjuster necessary to process insurance claims for the benefits that are payable under the terms of my insurance policy.

Insured Signature______________________ Date _____________

American Chiropractic & Acupuncture Financial Policy

Your insurance policy is an agreement between you and the insurance company. It is important that you understand your health and accident benefits listed in you policy. You or your guardian is personally responsible for any charges for services which are rendered to your account. There are many variations in the HMO's and PPO's of today. We request that you call your insurance company to get your Chiropractic Benefits within the first week of care. As a courtesy to you, our office will also call your insurance company to verify insurance coverage, BUT this is not a guarantee of what the insurance company will pay. We will try, to the best of our ability, ESTIMATE what your coinsurance/co-pay will be at each visit. It is our Office Policy to collect any deductibles, co-insurances or co-pays at EACH visit unless other arrangements are made.

ONCE NOTIFIED BY THE INSURANCE COMPANY THAT SERVICES RENDERED ARE NOT PAYABLE UNDER THE "MEDICAL NECESSITY" CLAUSE IN YOUR CONTRACT, YOU AGREE TO ACCEPT FULL RESPONSIBILITY FOR THOSE SERVICES. IF YOU ELECT TO CONTINUE CARE, YOU AGREE TO ACCEPT FULL RESPONSIBILITY FOR SERVICES RENDERED.

All insurance checks and payments will be assigned to our office. If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.

Any overpayment made by your insurance company on your account will be refunded. Any balance not paid by the insurance company ultimately becomes your responsibility. If care is terminated by the patient or the doctor, payment for services is due in full immediately. A late fee of 1% per month will be assessed to the unpaid balance after 30 days.

Patients with no insurance:
Full payment of patient obligation is due at the time services are rendered. We accept cash, personal checks, Visa and MasterCard as forms of payment. As a courtesy, payment plans are available for you and your family. If your situation requires special consideration, please let us know.

Returned Checks: There will be a $25 charge for all returned check.

Missed Appointments:
We understand that there may be extenuating circumstances affecting your schedule, and we will do our best to accommodate your needs. We ask that out of respect for our office policies that a 24-hour notice be given to any appointment that needs to be cancelled or rescheduled. If this notice is not given, a $25 fee will be charged to you. This fee is patient responsibility and can not be billed to insurance.

In signing this form, I have read and understood this information.

SIGNED____DATE_______________

American Chiropractic & Acupuncture
Patient Health Information (PHI) Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. We require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Patient Signature   Date