

Financial Policy For Chiropractic Health Care Associates

It is the intention of all personnel in this office to provide for your chiropractic needs as thoroughly and efficiently as possible. Therefore, we wish to acquaint you with our policies.

The initial appointment is spent conducting a thorough examination. It includes a clinical examination, history of symptoms, and x-rays, as indicated. "To see is to know, not to see is to guess". The more comprehensive the examination, the more intelligently we can diagnose and treat. From our study of x-rays and clinical findings, we will diagnose your case. On your second visit, we will discuss present and recommend proper treatment.

Please read the areas marked below.

INSURANCE:

_____ We participate, and submit to, a variety of health care insurance programs which aid in the payment of your medical costs. Should there be problems with an insurance claim, first direct your question to your insurance carrier. Our Insurance Office will be pleased to help you if they can be of any assistance in resolving a problem. It is YOUR responsibility to know if your insurance covers chiropractic care, or if you need to have pre-approved visits.

MEDICARE:

_____ Coverage of chiropractic services is specifically limited to manual manipulation of the spine to correct a subluxation. Medicare DOES NOT PAY FOR EXAMS, X-RAYS, THERAPIES, SUPPLEMENTS, OR ANY OTHER SERVICES RELATED TO CHIROPRACTIC CARE.

MEDICAID:

_____ Coverage of chiropractic services is specifically limited to manual manipulation of the spine and x-rays. If Medicaid is secondary to Medicare, Medicaid may not pay for x-rays. Medicaid DOES NOT PAY FOR EXAMS, THERAPIES, SUPPLEMENTS, OR ANY OTHER SERVICES RELATED TO CHIROPRACTIC CARE. There is a \$1.00 cop-pay per visit that must be paid at each visit. Exceptions to this is if you are under 21 years of age, or pregnant. We will need a copy of your Medicaid card each month.

NO INSURANCE (TOS):

If you have no insurance covering chiropractic care we request services be paid in full for the first visit at the first visit, and full payment at every visit thereafter.

PAYMENT:

If your insurance policy has a deductible or co-payment amount, it must be paid at the time of service. Your health insurance policy is an arrangement between you and your health insurance carrier, and you are ultimately responsible for all fees relating to your care.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

INTEREST:

We will charge, on patient past due accounts, a monthly finance charge of 1.5% on any balance 60 or more days overdue.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES.

Date

Patient Signature

Parent or Legal Guardian Signature

Chiropractic HealthCare Associates, P.C.
515 7 Avenue SE
Cedar Rapids, IA 52406-0996

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
_____ Cell Phone: _____
SSN: _____ Work phone: _____
Date of Birth: _____ Martial Status: M S W D
Occupation: _____ Employer: _____
Referred by (Dr.)?: _____ Ins. Company _____
Ins. ID#: _____ Group: _____ Ins. Phone #: _____
Insured Address: _____ Insured Date of Birth: _____
_____ Insured SSN: _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) _____ Yes
_____ No

Family Physician: _____ (Note: We will send your health information to this provider)

Person to contact in case of emergency (Name and Phone): _____

What operations have you had? _____ When? _____

Family History: _____ When? _____

Serious Illness: _____ When? _____

What medications or drugs are you taking? (check those that apply): Pain Killers ___ Insulin ___ Cholesterol Meds ___

Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

_____. Cardiac Devices: Y N Hip/Knee replacement: Y N

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AN PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to CHCA all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursements or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim.

CONSENT TO RELEASE INFORMATION

I give permission to Chiropractic Health Care Assoc.P.C. to release information concerning my treatment and account balance to _____ (name) and their relationship to me is _____.

I have read and fully understand this agreement.

_____ Signature of Insured/Guardian _____ Date

Symptoms and Ill Health (Present State of Ill Health)

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Midback Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Arm/Leg Pain | <input type="checkbox"/> Hand/Foot Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Spinal Arthritis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Fibro Myalgia | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> STD's | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Due Date | <input type="checkbox"/> Date of Last Menstrual Period |
| <input type="checkbox"/> Diffibulator | | | |

Symptoms and Ill Health (cont'd)

1. Circle the severity (1= No Pain to 10= Very Severe Pain) and Frequency or your pain (% of the week you experience the pain).
(Please list your conditions on the lines below and rate them from top to bottom in the order of severity)

Condition / Problem	Severity										Frequency (%of the week)											
	Minimal					Severe					Occasional					Constant						
1° _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
2° _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
3° _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
4° _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

2. When did your symptoms begin? _____
3. Has your condition? Improved _____ Gotten Worse _____ Stayed the same since its onset _____
4. Is your condition worse during certain times of the day? No _____ Yes _____ Explain if Yes: _____
5. Circle the things that make your problems worse: Bending - Twisting - Walking - Standing - Sitting - Movement - Lying - Lifting
6. Is there anything you can do to relieve the problem? No _____ Yes _____ Explain if Yes: _____
7. Have you been treated for this before? No _____ Yes _____ How long and by whom? _____
8. What treatment did you receive? Medication? _____
9. Results of previous treatment? Good _____ Poor _____ Comments: _____
10. Is this condition interfering with: Work _____ School _____ Daily Routine _____ Recreation _____ Sleep _____ Other _____
11. Approximate date of last Chiropractic visit? _____
12. Approximate date of last MD/DO visit? Doctors name? _____
13. List any major injuries you have had other than what might have been mentioned above? _____

14. To your knowledge, do you have or have you had any major illnesses, diseases, or injury, past or present that is not mentioned above?

Please list: _____

15. Have you had X-rays taken before? No _____ Yes _____ Explain if Yes: _____

Patient Signature: _____ Date: _____