

Patient and Insurance Information

- Please provide us with Id and your insurance card(s) to copy -

Name	email	Date
Address		
City	State	ZIP
Home Phone (day/eve)	Work Phone (day/eve)	Pager/Cell
(Circle best number to call first)		
Drivers License #	Birth Date	Soc Sec #
Marital Status M S D Sep	Spouse Name	# of Children
How Where You Referred to Our Office:		
Employer	Occupation	
Address	Emp Phone	
City	State	ZIP
In case of an Emergency Who can we Contact: someone who will know where you or your family members can be reached:		
Name	Address	City
Phone	Relationship	
Health Insurance Info		
Carrier	Ins Co phone	
Address		
ID #	Group #	
Patient Relationship to the insured Self Spouse Child Other		
If you are covered under another person's insurance.... Please complete		
Name of Subscriber		
Address of Subscriber		
Phone of Subscriber	Sex	Subscribers Birth date
Subscriber's Employer		
Address		
Employer Phone	Plan Name	
Where Were You Injured (check box): <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Other		
<p>I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate treatment in this office, any fees for professional services rendered me will be immediately due and payable.</p> <p>I hereby Authorize the Doctor to treat my condition, as he or she deems appropriate. It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis.</p>		
Patient Signature _____		Date _____
Consent to treat a Minor _____		Date _____
Guardian or Spouse's Signature to of Authorizing Care _____		Date _____

Health History

Patient Name _____ Date _____

Describe Your Health Problem (What brought you in to the Clinic today): _____

If this is a Work injury or Auto Injury please complete additional Questionnaire forms (if you do not have these ask the receptionist for a copy)

How long have you had this condition? _____ Is it getting worse? _____ What makes it worse and what makes it better? _____

Does it bother you during: Work Sleep Other (specify) _____

What seemed to be the initial cause _____

Have you seen a Chiropractor before? Yes No

If Yes, Name of Dr. _____ Where _____ How long ago _____

For what reason _____

Are you currently under care of a medical physician? _____ If Yes for what reason _____

List any Accidents, Surgeries, or Falls, with dates _____

List any broken bones or dislocations, with dates _____

Were you ever knocked unconscious? _____ How and when? _____

Have you ever had a lapse of memory? _____ When? _____

List any X-rays you have had taken: _____

Do you Suffer from any conditions other than that which you are now consulting us? _____

Are you currently taking any, prescription or over the counter medication? Yes No If Yes list Names of Drugs _____

List any Nutrients you presently are taking _____

Please provide any important "Current" Information not asked _____

Billing Policy

Patient Name: _____

In the event that I am accepted for Chiropractic care from this office I hereby give my authorization to receive such services.

I understand that the doctors at Summers Chiropractic and Massage treat only subluxations and provide treatment for the removal of the cause of the vertebral subluxation complex. The Chiropractor does not treat other medically diagnosed entities, nor is the Chiropractor responsible for the diagnosis or treatment of any medically diagnosed disease or illness, either current or prior.

I hereby assign all chiropractic benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and all other health plans to Summers Chiropractic and Massage.

I authorize release of patient records to third parties requiring these for determination of financial liability.

I understand that health and accident insurance policies are an arrangement between the carrier and the patient, which are usually designed to offset a large portion of the total cost. I also request Summers Chiropractic and Massage to prepare any necessary reports and forms to assist in making collections from the insurance company to the patient, or any amount authorized paid directly to this office will be credited to the patient's account. I understand that all services furnished are charged directly to the patient who is personally responsible for payment, including the small charge for completing these forms. Summers Chiropractic and Massage does not bill secondary providers, except where contractually obligated. The patient must inform Summers Chiropractic and Massage as to where to send any and all patient's bills. All unpaid balances become due and payable in full when care is terminated. Summers Chiropractic and Massage will bill the insurance company only one time before a billing and finance charge may be incurred. The patient assumes responsibility for any and all costs incurred by Summers Chiropractic and Massage for the collections of any outstanding bill.

In some cases, a doctor's lien may be implemented; the expense of preparing and filing this lien will be charged to the patient. Workman's Comp/Labor and Industry claims will be billed directly to the carrier. If these bills are refused or denied all charges become the responsibility of the patient.

If I should be now, or in the future, under a managed care insurance program, by signing my name below I understand that Summers Chiropractic and Massage will bill my insurance company for services rendered to me. If my insurance company denies payment due to lack of referral from my primary care physician I will expect Summers Chiropractic and Massage to bill me for these services and I further understand that I will be held financially responsible for said services.

NAME OF THE PERSON RESPONSIBLE FOR PAYMENT:

RELATIONSHIP TO THE PATIENT: _____

PATIENT'S PRINTED NAME: _____

PATIENT'S SIGNATURE: _____ DATE: _____

Guarantor's signature (if different than the patient): _____
(Please provide pertinent information to office)

Guarantor's Printed Name: _____ WDL# _____

Summers Chiropractic and Massage Patient Health Information 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. Before we will begin any health care operations we must 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 HIPAA 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 P HI 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 health care operations, the chiropractic physician 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.

Name of Patient

Date