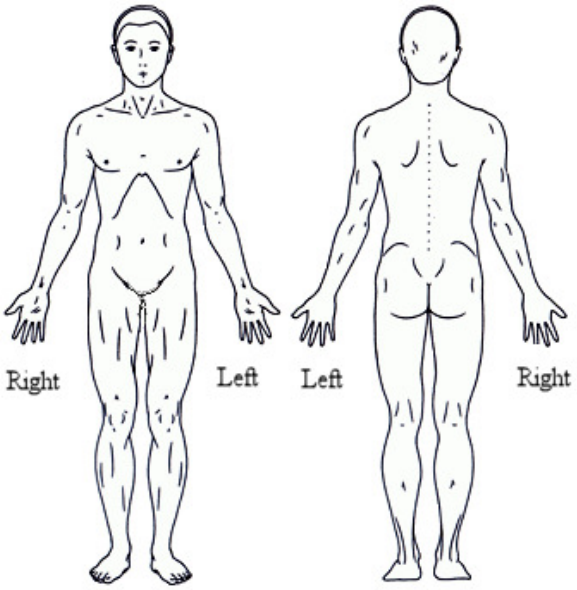
Woodbury Family Chiropractic

Name_____ Age_____ Height _____ Weight _____ lbs. Today's Date___/___/_____
Address_____ City_____ State_____ Zip_____
Cell#_____Home#_____Date of Birth ___/___/_____ Sex: M F
E-Mail Address: _____How did you hear about us?_____
Occupation/Employer _____ Phone (Work)_____
Insurance Company_____Phone_____
Insured's Name _____ Insured's Date of Birth _____
Insured's Group # _____ Insured's address same? Y N
Spouse's Name _____Children's Names/Ages_____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

HEALTH REPORT:
Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
Have you taken medication in the past? __ Yes __ No list medications _____
List conditions you are taking medications for: _____
List the approximate dates of any surgery or treated conditions:_____
_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

Do you smoke Y/N ____ • Alcohol Y/N __Daily __Weekly __Social Occasions • Caffeinated drinks per day _____



Is this condition progressively getting worse?_____

Do you take Vitamins/Supplements Y/N If yes, type and how often _____Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel discomfort:

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

When did the current complaint begin? _____
How long have you had these symptoms?_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____ Routine?_____Other?_____

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS

__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR

__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT

__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL

__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY

__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY

__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES

__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY

__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date_____

Woodbury Family Chiropractic

I, _____ [Name of Individual] consent to Woodbury Family Chiropractic, “the Practice’s”, use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice**. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document.** The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____

Signature or Personal Representative Date

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize the Doctor of Woodbury Family Chiropractic to administer care as they so deem necessary to my son / daughter.

Parent or guardian Signature _____ Date _____

Do we have permission to leave a detailed voice or text message on your provided number? ___ YES ___ NO

Woodbury Family Chiropractic

Financial Policy

Thank you for choosing Woodbury Family Chiropractic for your chiropractic care. We are committed to providing the highest quality chiropractic care and service. We will recommend and provide appropriate and necessary services without regard to the limitations imposed by insurance coverage. Our practice is “patient-centered” rather than “insurance-centered”. The following is a statement of our Financial Policy, which we require you to read and sign.

INSURANCE: As a courtesy, we offer you an estimate for recommended treatment. All estimated patient portions and/or copays are due at the time of service. At any time, if you have questions regarding your insurance plan as it relates to your treatment, we will be happy to try and answer them to the best of our knowledge. However, we encourage you to refer to your benefits manual or customer services if you have any questions about covered services. Please keep in mind your insurance is a contract between you and the insurance company. Your involvement in the process of providing us with proper information, and you being proactive in knowing your plan, will help to maximize your benefits to their full potential.

Our acceptance of insurance assignments does not absolve you of full responsibility for the treatment rendered. The estimate provided is to be considered a guideline until the final insurance payment is received and your account has been reconciled. The estimate is not a guarantee of insurance payment. If your plan has a reduced fee schedule or a provider network, it is your responsibility to be sure we are a participating (in-network) provider.

MINOR PATIENTS: Minors (under the age of 18) must be accompanied by a parent or legal guardian at their initial visit. The parent or legal guardian is responsible for the estimated patient portion and/or copays when treatment is rendered. The parent or legal guardian is required to notify our office of any changes in the minor’s medical history prior to treatment.

DIVORCE DECREES: Our office is not party to your divorce decree. The parent or legal guardian who accompanies the minor at the appointment is responsible for payment of the estimated patient portion and/or copays.

COLLECTIONS AND RETURNED CHECKS: Accounts outstanding more than 90 days from treatment date will be subject to a collections agency. A $30 service fee will be applied for checks that are returned for any reason.

MISSED APPOINTMENTS: We understand that at times it may be necessary to reschedule an appointment. If that need should arise, we request that you call the practice on a business day, at least 2 hours in advance of the scheduled chiropractic appointment. 24 hour notice is required for all massage therapy and acupuncture appointments. Unless canceled 24 hours in advance, a Late Cancel Appointment fee is charged to your account. This fee is not covered by your insurance and will be your responsibility. Should a pattern of missed appointments be determined, future appointments may be impacted.

Patient Signature_____ Date _____

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Medical Necessity Policy

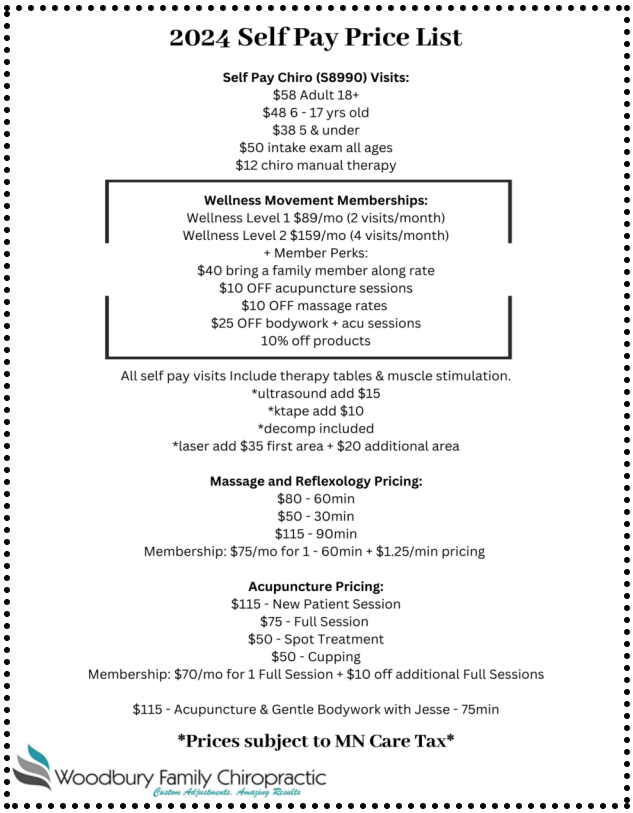
The following is a statement of our Medical Necessity Policy, which we require you to read and sign.

Insurance payers only cover care they deem 'medically necessary' and this can best be understood as coverage for a series of consecutive visits for rehabilitation of acute musculoskeletal pain or dysfunction conditions. They do not cover care that is intended for maintenance or wellness conditions. This is why it is important to follow the treatment plan your provider recommends so that you may get the insurance benefit and result you are covered for.

Insurance companies can and have selectively retracted payment for years of visits from our clinic when retrospectively deeming the care does not meet their standard of 'medical necessity'. As ethical practitioners, we would only bill insurance if we believed patient care was medically necessary. Unfortunately, insurance companies overrule us due to their business management of patient care.

In an effort to continue to provide care to patients, without surprise bills on either side of the arrangement, we will no longer submit more than 20 chiropractic visits per year to an insurance policy. We have been told that billing beyond 20 visits, no matter the visit limit told to members, will result in our clinic being flagged and potentially audited. This is a risk we do not have the bandwidth to take on.

We do offer SELF-PAY rates for wellness care in house that allows patient care to continue at a discounted rate. We have pay as you go rates, as well as wellness memberships with member perks for these non-medically necessary visit types. Please ask our staff or providers for more information on how you can save money on chiropractic care with our wellness care options. These visit types often can be submitted for reimbursement by HSA or flex spending accounts, though they are not billed with the same coding as insurance visits that are medically necessary care by contrast.



Patient Signature_____ Date _____