

James Chiropractic
4249 N. St. Peters Pkwy. Suite A
St. Peters, MO 63304

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date _____ Name _____
Nickname _____ Address _____
City _____ State _____ Zip _____ Date of Birth _____ Age _____
Gender (check one) M F Marital Status (check one) Married Widowed Other
 Single Divorced

Race (check one)
 White Black/African American Hispanic Asian
 Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown I choose not to specify

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)
 English Spanish Other _____ I choose not to specify

Home Phone _____ Work Phone _____ Mobile Phone _____
Social Security# _____ E-Mail _____
Occupation: _____ Employer _____
Employer Address _____
City _____ State _____ Zip _____

Which method do you prefer for us to communicate with you (check one):
 Home Phone Work Phone Mobile Phone Email

Employment Status (check one):
 Employed FT Student PT Student Other Retired Self Employed

Who referred you to this office? _____

Spouse Info: Name _____ Number of children/ dependents _____
Date of Birth _____ Employer _____
Address _____

Insurance Info:
Primary Carrier: _____ Secondary _____

Is this an accident? Yes No If so, date of injury _____
() Auto accident () State Compensation () On the Job Injury () other

Have you reported a work related injury to your employer? yes no

How did you get injured? _____

Name and Address of Attorney advising you _____

Patient Name: _____ **Date:** _____

List your main complaints in order of severity:

1. _____ For how long? _____ # previous incidents _____
2. _____ For how long? _____ # previous incidents _____
3. _____ For how long? _____ # previous incidents _____

Have you ever had Chiropractic care before? _____ If so when? _____
By whom? _____ For what condition? _____

List other Doctors consulted on above complaints:

1. _____ Address _____
2. _____ Address _____

Have you had this or a similar condition in the past? ___yes___ no

Is this condition interfering with your ___work___ sleep___ daily routine

What do you believe is wrong with you? _____

Do you currently **smoke tobacco** of any kind? ___Yes___ Former Smoker ___Never been a smoker
If yes, how often do you smoke: ___Current every day smoker___ Current smoker sometimes

Alcohol use: Y/N ___per day **Drugs:** Y/N ___per day

How many caffeinated drinks do you consume per day?

___None___ ___less than 3___ ___3-6___ ___more than 6___

Exercise: ___Never___ ___Daily___ ___Weekly___ Other: _____

Are you aware of any inherited diseases in your family, including High Blood Pressure, Heart Disease, Stroke, Heart Attack, Diabetes and/or Cancer? ___Yes___ No___ **IF YES, PLEASE LIST DISEASE & RELATIONSHIP TO YOU:**

- 1) _____ 3) _____
- 2) _____ 4) _____

Have you ever been **hospitalized FOR ANY REASON?** ___NO___ ___YES (List approximate dates/reason)

Current Medications, including **Strength, dosage, frequency, and Prescribing Physician**, if known.

If there are no current medications, check here: ___

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

Patient Name: _____ **Date:** _____

List any known **ALLERGIES AND REACTIONS** you have had to any medications.

If no allergies are known, check here: ___

1) _____ Reaction _____ 3) _____ Reaction _____
2) _____ Reaction _____ 4) _____ Reaction _____

Briefly list your **MAIN HEALTH PROBLEMS:**

Has any doctor diagnosed you with **HYPERTENSION** presently? ___Yes ___No

If yes, describe: _____

Has any doctor diagnosed you with **DIABETES** presently? ___Yes ___No

If yes, what kind? ___Type I ___Type II

Past History:

Please list **ANY SURGERIES** that you have had, including **approximate DATE(S):**

Please indicate whether you have had **ANY** of the following, including **DATE, SEVERITY** and **TYPE OF INJURY:**

Motor vehicle accident: _____

Serious Falls: _____

Fractures: _____

Tumors: _____

Cosmetic Surgeries: _____

Date of last menstrual period: _____

Other: _____

Have you had **ANY X-ray, CT Scan, or MRI** in the past two (2) Years? ___ YES ___NO

If yes, please list **dates and where the x-rays were taken** _____

*******If your medical records are requested by anyone **without a Release of Information signed by You**, they will be required to provide the answer to one of the questions below:

Verification Question (choose only one question by checking the question, then give the answer to that question)

- | | |
|--|-------------------------------------|
| ___ What is the name of your favorite pet? | ___ In what city were you born? |
| ___ What High School did you attend? | ___ What is your favorite movie? |
| ___ What is your mother's maiden name? | ___ On what street did you grow up? |
| ___ What was the make of your first car? | ___ When is your anniversary? |
| ___ What is your favorite color? | |

Verification Answer to the Chosen Question: _____

James Chiropractic Financial Policy

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic center. **We are not certain if your insurance covers chiropractic, although most policies do provide coverage.** The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage or co-pay as stated in your policy. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. We allow one resubmission of claims at no charge. If your insurance company fails to process the claims after a second submission you will be required to pay for services and seek reimbursement from your insurance company. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible in the event that your insurance company denies payment. We will assist you in verifying your insurance coverage; however, it is your responsibility to know the provisions of your particular policy. When all insurance checks have been received, we will refund any overpayment to you.

PATIENTS WITHOUT INSURANCE: An increasing number of patients do not have insurance, or have plans with limited coverage, such as catastrophic policies. We realize that no one wants to build up a large bill. Therefore, we have several plans so those patients may receive complete care without undue financial difficulty. Of course we are always happy to accept cash, your personal check, MasterCard, or Visa. We request that 100% of the first visit be paid at the time of the first visit.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid **as long as you are an active patient and do not have major medical or medical payments coverage.** We do not accept provider discounts because the liability carrier or medical payments coverage is the primary insurance company all others are secondary. If you suspend or terminate care any fees and services are due immediately. We will contact your attorney and insurance companies to begin settlement procedures upon release from active care. If your case is not settled within 90 days from your release, we will require you to make partial payments of 20% of your outstanding balance for the next five (5) months. At any point settlement is reached, your account is due and payable in full immediately.

MEDICARE: We do accept assignment from Medicare. The check is usually sent directly to us in payment of services that Medicare will cover. For chiropractors, this includes **only** manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. The patient is also responsible for payment of all non-covered services when they are rendered. Subsequent services will be payable at each visit unless other arrangements are made. Our office will complete the necessary forms and file them with the Medicare provider at no charge. We allow one resubmission of your claim at no charge.

“ON THE JOB INJURY”: Worker's Compensation pays in full for chiropractic care **when approved by your employer.** You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with the proper information, or if settlement has not been made within three (3) months, or if you suspend or terminate care, any fees for services are due immediately.

**Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics, and nutritional supplements, etc. at the time they are provided to you.

** If my account is turned over to collections, all collection fees will be in addition to the account balance.

Note: Your health information will be kept confidential. Any information we collect about you will be kept confidentially in our offices. If a claim is submitted to an insurance provider, your health information may be shared with the insurance company. The insurance company will keep your information confidential.

Signature _____

Date _____

James Chiropractic

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Notice of Privacy Practices

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice.

It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands-on care and treatment of patients in our office as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process.

In some cases, patients may wish to have their protected health information released. In those cases, if the outside entity can provide us with a copy of a medical records release form signed by the patient then we will comply while still providing only the minimum necessary information, or the amount of information requested by the patient.

In cases of public health, HIPAA does not protect some information where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases, we will follow the most restrictive laws, state or federal, that apply in protecting your medical information. You, as a patient have a right to see your medical record during normal office hours.

Additional Uses of Your Health Information

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will not release a mailing list to any outside entity for solicitation of business not related to our office.

James Chiropractic

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive payment and/or as part of health care operations of our practice.

HIPAA also requires us to have written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions, but if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Do we have permission to discuss your treatment or financial arrangements with your spouse?

(Circle One) YES NO

Do we have permission to discuss your treatment with your direct family?

(Circle One) YES NO

Patient Signature _____ Date _____

Restrictions:

Doctor/Staff Signature _____ Date _____