James Chiropractic
New Patient

Please present your ID and current insurance card. Thank you.

DATE: _____

NAME: _____

List your main complaints in order of severity:

1. _____For how long?_____

2. _____For how long?_____

3. _____For how long?_____

I RATE MY PAIN (10 being the worst): 1 2 3 4 5 6 7 8 9 10

HOW WERE YOU INJURED? _____

WHEN DID SYMPTOMS BEGIN? _____

WHAT MAKES PAIN WORSE? _____

_____

HAVE YOU TRIED ANYTHING FOR THE PAIN? DOES IT HELP? _____

_____

DESCRIBE YOUR PAIN/DISCOMFORT: _____

_____

DOES PAIN INTERFERE WITH SLEEP? Yes / No **WORK?** Yes / No **DAILY ROUTINE?** Yes / No

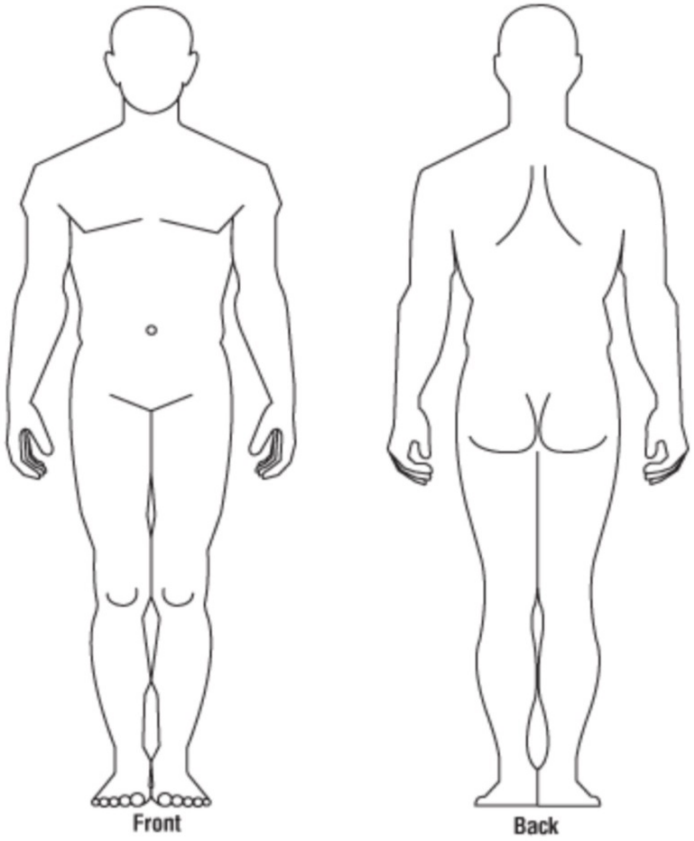
DOES PAIN RADIATE TO OTHER AREAS? Yes / No **IF SO, WHERE?**

_____

DO YOU HAVE ANY TINGLING OR NUMBNESS? Yes / No **IF SO, WHERE?**

_____

Height	Weight	BP	Pulse	SpO2



_____ minutes total time spent performing evaluation and management.

Cervical ROM	Lumbar ROM
Flexion _____	_____
Extension _____	_____
L Rotation _____	_____
R Rotation _____	_____
L Lat Flex _____	_____
R Lat Flex _____	_____
SLR R _____	_____
SLR L _____	_____

Dej Triad	BW/BL	Fabere-Patrick	Cervical Compression
_____	_____	R_____L_____	R_____L_____

PLAN: _____

_____

GOALS: _____

_____

Exam _____ Re-Exam _____

X-Rays _____ THEX _____

Adj. 1-2 _____ 3-4 _____ 5+ _____

Extra Spinal _____

MS _____ TR _____ US _____

Acupuncture _____

Diagnosis Codes

_____

_____

_____

_____

_____

_____

_____

James Chiropractic
Quinn J. James, D.C.
4249 N. St. Peters Parkway, Suite A
St. Peters, Missouri 63304
Phone: (636) 441-9240 www.dcjames.com Fax: (636) 441-2224

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date: _____ Name: _____

Nickname: _____ Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ Age _____

Gender: _____ E-Mail: _____

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Spouse Name: _____ Number of children/dependents: _____

Insurance Company:_____

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

Have you ever had Chiropractic care before? _____Yes _____No If so, when? _____

By whom? _____ For what condition? _____

Who referred you to this office? Please circle: Google, Insurance, Doctor, Attorney, Patient: _____

Have you consulted Doctors/Hospitals/Urgent Care for THIS condition? ___ YES ___NO If yes, please list:

1. _____Address_____

2. _____Address_____

Have you had ANY X-ray, CT Scan, or MRI? ___ YES ___NO If yes, please list **dates and locations:**

1. _____Address_____

2. _____Address_____

Have you been diagnosed with any conditions? ___YES ___NO If yes, please list:

1)_____ 3)_____

2)_____ 4)_____

Patient Name:_____Date:_____

Please list current medications or provide list to include **strength, dosage, frequency, and prescribing physician**:

If there are no current medications, check here: ___

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

NOT INCLUDING YOURSELF: 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 & <u>RELATIONSHIP TO YOU</u>:

1)_____ 3)_____

2)_____ 4)_____

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_____

Has any doctor diagnosed you with **HYPERTENSION (High Blood Pressure)** presently? ___Yes ___No

Has any doctor diagnosed you with **OSTEOPOROSIS** or **OSTEOPENIA**? ___Yes ___No

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

If yes, what type? ___Type I ___Type II

Alcohol use: Y/N _____per day Do you currently have a **drug or substance abuse problem:** Y/N

Exercise: ____Never ____Daily ____Weekly ____Occasionally Other:_____

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

REV: 8/19/21

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. I request payment of government benefits either to myself or to the party who accepts assignment below.

"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**_____

Rev. 10/9/13

Charleston Square Chiropractic LLC d/b/a James Chiropractic
4249 N. St. Peters Parkway, Suite A
Phone: (636) 441-9240 St. Peters, Missouri 63304 Fax: (636) 441-2224

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from Charleston Square Chiropractic LLC dba James Chiropractic ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims on my and/or my dependents' behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan; (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance olicy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of the Assignment/Authorization shall be as effective and valid as the original.

_____ _____
Patient Date

_____ _____
Policyholder/Insured Date

James Chiropractic
Quinn J. James, D.C.
4249 N. St. Peters Parkway
Suite A
St. Peters, Missouri 63304
www.dcjames.com
Phone: (636) 441-9240 Fax: (636) 441-2224

Consent to use Protected Health Information

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Charleston Square Chiropractic, LLC d/b/a James Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____