Account #_____

Date:_____**Dr:**_____

Welcome – New Patient Paperwork

(Please Print) GENERAL INFORMATION

Your Name:(First)_____(Middle)_____(Last)_____

Address:(Street)_____City:_____State:_____Zip:_____

Nick Name:_____SS#_____

Home #:_____ Work #:_____Cell#:_____

Marital Status:_____Date of Birth:_____ Sex: M_____ F_____

Occupation:_____E-Mail Address:_____

Your Employer:_____Employer Address:_____

Emergency Contact, Name: _____ Phone #_____Relationship_____

Spouse's Name:_____Home #_____Work #_____

Is your visit related to an: Auto Accident ?_____ Workers Compensation Claim? _____

How did you hear about our office; whom may we thank for this referral: Phone Book_____

Patient:_____ Dr.'s Name:_____ Ins. Comp.____Other:_____

INSURANCE INFORMATION

What is your Primary Insurance:_____

Are you the primary card holder: Yes____ No_____. If not, who is?_____

Do you Require Referrals/Authorizations for a Specialist: Yes_____ or No _____

Do you usually have a Copay with a Specialist? Yes____ or No _____ If so, how much?_____

What is your Policy #:_____ What is your Group #:_____

Do you have Secondary Insurance? _____ What Insurance?_____

MEDICAL INFORMATION

Are you Pregnant? Yes or No If so, Due Date:_____ Are you Dieting?_____ What Type of Diet?_____ Have you seen a Chiropractor before?_____ When?_____

Describe Primary Complaint / Symptoms:_____

_____

_____

When did symptoms appear?_____Severity of Pain(1=least to 10 = severe)? _____

Type of Pain? (Circle if applicable)

Sharp, Dull, Throbbing, Aching, Shooting, Burning, Tingling, Other:_____

What is frequency of Pain? (Circle if applicable)

Constant, Comes and goes, Morning only, Evenings only , Other:_____

Do symptoms interfere with? (Circle if applicable)

Walking, Sitting, Standing, Sleeping, Bending, Working, Recreation, Other:_____

MEDICAL HISTORY

Account #:

#1 Check Y=Yes or N= No If you have or have ever had any of the following.

#2 Check Box & Complete Information. **#3 & #4** Complete All Information

#1	Y	N		Y	N		Y	N		Y	N
AIDS/HIV			Emphysema			Miscarriage			Scarlet Fever		
Alcoholism			Epilepsy			Mononucleosis			Stroke		
Allergy Shots			Fractures			Multiple. Sclerosis			Suicide Attempt		
Anemia			Glaucoma			Mumps			Thyroid Problems		
Anorexia			Goiter			Osteoporosis			Tonsilitis		
Appendicitis			Gonorrhea			Pacemaker			Tuberculosis		
Arthritis			Gout			Parkinson's Disease			Tumors, Growths		
Asthma			Heart Disease			Pinched Nerve			Typhoid Fever		
Bleeding Disorders			Hepatitis			Pneumonia			Ulcers		
Breast Lumps			Hernia			Polio			Vaginal Infections		
Bronchitis			Herpes			Prostrate Problem			Venereal Disease		
Bulimia			High Cholesterol			Prosthesis			Whooping Cough		
Cancer_____			Kidney Disease			Psychiatric Care			Measles		
Chicken Pox			Diabetes			Rheumatic Fever			Cataracts		
Chemical Depend.			Liver Disease			Rheum. Arthritis			Migraine Headache		

#2	**Exercise**	**Work Activity**	**Habits**

None		Sitting		Smoking		Pack per Day	
Moderate		Standing		Alcohol		Drinks per Week	
Daily		Light Labor		Coffee/Caffeine Drinks		Cups per Day	
Heavy		Heavy Labor		High Stress Level			

#3	**Injuries/ Surgeries**	**Description**	**Date**
Surgeries			
Head Injury			
Broken Bones			
Dislocations			

#4	**Medications You Take**	**Allergies You Have**	**Vitamins/ Minerals/ Herbs Taken**

Account #_____

Financial Policy, Consent and Release of Medical Information

Financial Policy: All patients are financially responsible for all charges incurred in this office. Further;

1) If you have Chiropractic Coverage, our office will submit to your Primary Insurance Company ONLY. If you have a secondary Insurance Company, you will be responsible for submitting any claims to that Insurance.

2) If for any reason your Insurance Company denies payment of any claims submitted, you will be responsible for payment of such denied claims.

3) Please remember, in most instances, it is your responsibility to obtain referrals for your visits if required by your Insurance Company. If you choose to be treated without a referral or authorization, you will be responsible for the entire fee if denied by your Insurance.

4) Some Insurance Companies pay the policy holder instead of the Doctor. It is your responsibility to notify our office if your Insurance Company pays you and to make appropriate arrangements to reimburse this office for those services.

5) If you fail to provide or complete any information required by your Insurance Company within a reasonable time frame, you will be responsible for payment of any claims related to the failure to supply this information to your Insurance Company.

6) Typically, most insurance companies deny payment for visits that relate to preventative or supportive care. Consequently, if your Insurance Company does not cover such services, no claim will be submitted for these services and you will be responsible for payment at the time services are provided.

7) Insurance Companies usually pay based on a "Usual and Customary" rate or fee. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If there is a difference between what your Insurance Company pays for and our fees, you will be responsible for the difference. This does not apply to Insurance Companies for which we are considered "Providers" unless you have a non-covered service rendered (i.e., xrays).

Consent of Treatment for Minor Child:

Minor patients (under age 18) will only be seen if permission is granted, in writing, by a parent or guardian.

My signature below indicates I consent to procedures to be performed on/to my minor child (Child's name)_____ at Olney Chiropractic Center.

(Authorized Signature):_____(Printed Name)_____

(Relationship to Minor Child):_____

Missed appointments:

Appointments which are canceled less than 24 hours in advance, are subject to a charge at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments and by calling in advance of missed appointments.

Account #_____

Charges for Returned Checks and Collection Services:

There will be a $25.00 charge for each returned check. There will also be a $25.00 fee for overdue accounts that must be submitted to a collection service plus any other costs associated with collecting on the account.

Medical Release:

I hereby authorize Olney Chiropractic Center (and it's doctors) to apply for benefits on my behalf for services rendered to me or my minor child if applicable as noted above. I assign directly to Dr. Ring, Olney Chiropractic Center, all insurance benefits otherwise payable to me for services rendered by Olney Chiropractic Center. In addition, I hereby authorize the Olney Chiropractic Center to release all information necessary to secure the payment of benefits and I authorize the use of this signature on all insurance submissions and permit a copy of this authorization to be used in place of the original.

Specific Doctor Notes: I further authorize Olney Chiropractic Center to release my medical records to:

Name:_____Address_____

City_____State_____Zip Code_____ Phone #_____

Agreement:

I certify that the information I have reported with regard to my insurance is correct. I agree to this entire Financial Policy including that I am financially responsible for all charges related to any treatment provided to me (or my minor child) by Olney Chiropractic Center. In the event these charges are not paid for by my Insurance, I agree to make full payment for all services related to my (or my minor child's) medical care including any fees related to any collection activity required because of non payment of such debt.

SIGNATURES:

X_____ X_____ _____

Printed Name Patient/Responsible Party Signature Patient/Responsible Party DATE

Relationship to Patient: Self_____ Spouse:_____ Parent:_____ Other_____

Privacy Notice: Consent for the Use and Disclosure of Information

By signing below you acknowledge that you have received a copy of the Privacy Notice for this office. You also consent to the use and disclosure of Protected Health Care Information about you for treatment, payment, and health care operations. You may also request to view the un-abridged version of the Privacy Notice. If there is any other person you wish to have information about you, please indicate that person in the space provided.

X_____ X_____ _____

Printed Name Patient/Responsible Party Signature of Patient/Responsible Party DATE

Other Person(s) you wish to have information about you:

Name and Relationship to you:_____