Family Chiropractic and Health Center, P.C.

Date _____ Whom may we thank for referring you? _____

PATIENT INFORMATION

Name_____ S.S. _____
Last Name First Name Initial

Address_____
Street or box # City State Zip
Email address_____

Home Phone_____ Cell Phone_____ _____
Best # and time to reach you
Marital Status_____ Birthdate_____ Minor Y/N Driver Lic # _____

Occupation _____ Employer_____

Spouse's Name _____ Birthdate _____ S.S.xxx-xx- _ _ _ _

Employer Address_____Employer Phone _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship_____ Phone _____

INSURANCE INFORMATION
Who is responsible for this account?_____Relationship_____
Insurance Co._____ ID # _____Group#_____
Insured's Name _____ Date of Birth_____
Do you have a secondary Insurance? _____
Insured's Name _____ Date of Birth_____
Insurance I.D.# _____ S.S # _____-_____-_____
Group # _____Relationship to patient _____
ACCIDENT INFORMATION
Is this condition due to an accident? ____yes _____no Date of accident _____
Type of Accident_____Auto_____Work_____ Home _____Other_____
To who have you made a report of your accident? _____
Auto Insurance_____ Employer_____ Workers Comp. _____ Other____
CHIROPRACTIC CONDITION

Describe your Chiropractic problem?_____
Have you ever received Chiropractic care? _____ If so give Name of DR._____
Who is your medical Doctor? _____
List medications you are presently taking_____
List any surgeries or hospitalizations_____

ASSIGMENT AND RELEASE
I certify that the information on this form is correct and I authorize the doctors to treat me. I understand that I am financially responsible for all charges for services rendered. If I am insured, I do hereby authorize the release of information for completing and filing of insurance claims, and I do authorize my insurance company to give direct payment to Family Chiropractic and Health Center, P.C. In the event it becomes necessary for Family Chiropractic to take legal action for the collection of said charges, I agree to pay all reasonable attorney's fees and collection expenses.

Date_____ Signature_____
Patient, Parent or Guardian

FINANCIAL POLICY

Our Practice Financial Policy

We are committed to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.
Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of services. For your convenience, we accept Visa, MasterCard and Discover.

Your Insurance

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-pay at the time of services. The co-pay will be collected immediately following services rendered. In the event that your health plan determines that a service not be covered, you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with plan with which we do not have a prior agreement, we will prepare and send the claim for you, as a courtesy. In this case, your insurer may send the payment directly to you; therefore charges for your care and treatment are due at time of service.

Minor Patients

For all services rendered to minor patients, the adult accompanying them is responsible for payment. Children 14 years of age or younger should be accompanied by a parent or legal guardian for treatment.

Massages—Insurance Coverage/ Missed Appointments

Family Chiropractic and Health Center, P.C. is unable to bill your insurance for massage. Effective January 2007 our office was notified that massage therapist are not recognized as providers. **All monies for massage are due at the time of service.**
In order to provide the best possible service and availability to all of our massage patients, it is our policy that you notify us at least **24 hours prior to cancellation.** Failure to cancel within these guidelines will result in a full charge for the time missed.

I have read and understand the financial policy of **Family Chiropractic & Health Center, P.C.** and agree to be bound by its terms. I also understand and agree such terms may be amended from time to time by **Family Chiropractic & Health Center, P.C.**

_____ _____
Please Print Name of Patient Date

_____
Signature of Patient or Responsible Party if Minor

Functional Rating Index

For use with Neck &/ Back Problems

In order to properly assess your condition, we must understand how your neck and/ or back problems have affected your ability to manage everyday activities. For each item below, please circle the number that most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc)

0	1	2	3	4
No Pain/ No restrictions	Mild Pain No restrictions	Moderate Pain/ need to go slowly	Moderate Pain/ need some assistance	Severe Pain/ 100% assistance

4. Travel

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work Plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Exercise/ Recreation

0	1	2	3	4
Able to do all exercise Without restriction	able to do most exercise	able to do most exercise/some restriction & soreness the next day	able to do some exercise/ considerable restrictions/ severe pain next day	unable to exercise

FAMILY CHIROPRACTIC AND HEALTH CENTER, P.C.

(Please Print)

Please complete this form to the best of your ability. It may be attached to your billing and sent to the insurance company to support your care.

My Pain keeps me from: Walking__ Sitting__ Standing ___Working__ Lying__ Sleeping___

What makes me feel better is: Ice___ Heat___ Medication___ Rest___ Sitting___ Lying___

Other _____

Please place a mark on the line below to indicate your present pain level

At Present

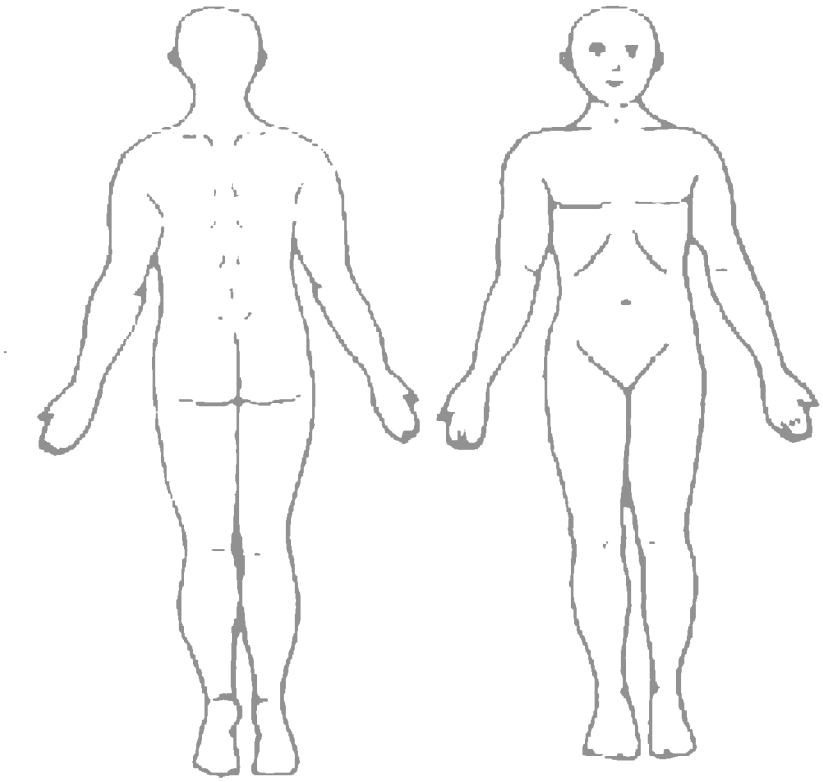
No Pain_____Worst Pain Ever

At Worst

No Pain _____Worst Pain Ever

Using a scale of 1-100 with 0 = no pain and 100 = worst possible ever, please write the number indicating your present pain level in the space below_____

On the Figures below, mark the areas of pain/complaint you have using the following symbols:
B= Burning S= Stabbing N= Numb T-Tingling D=Dull SH= Sharp A=Ache ST= stiffness



Patient Signature _____ Date_____

Print Name _____

PATIENT CONSENT

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

RELEASE OF INFORMATION:
By signing this form you are granting consent to **Family Chiropractic and Health Center**, **P.C.** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (251) 621- 0700. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/ or Title XI of the Social Security Act is correct, I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim.

VERIFICATION OF NON- PREGNANCY (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last Menstrual period_____

X_____
Print Patient's Name
X_____
Patient signature
X _____
Other Than Patient, Print Name & Relationship
X _____
Witness

FAMILY CHIROPRACTIC AND HEALTH CENTER, P.C.

General Release of Medical Records & X-Rays

Know All Men by These Presents: that I requested the release of the records and X-Rays of

_____

which are part of the records of _____

I hereby acknowledge receipt of these records and x-rays. In consideration of the foregoing, I hereby release and forever discharge Family Chiropractic and Health Center, PC, Dr. Kenneth A. Robinson and Dr. Gregory A. Kuhlmann from any and all responsibility of any kind, nature and character whatsoever arising from said treatment. You may refuse to sign this authorization.

Signature_____DOB_____

SSN_____Date_____

Witness _____

The information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing this form, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

Dr. Kenneth A. Robinson Dr. Gregory A. Kuhlmann
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Daphne, Alabama 36526
Office: (251) 621-0700
Fax: (251) 621-8187