Chiropractic Case History/Patient Information

Pt #____

Name _____ Social Security #_____ Home Phone _____

Address _____ City _____State_____ Zip _____

E-mail address: _____ Fax # _____ Cell Phone _____

Age _____ Birth Date_____ Marital: M S W D How many children?_____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer_____

Name of Nearest Relative _____ Address_____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? □ Yes □No If yes, when and describe: _____

_____

Days lost from work _____

Date of last physical examination _____ What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates) _____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

_____

What medications or drugs are you taking? _____

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders	□ Hernia
□ Backaches	□ Headaches	□ Nervousness	□ Neuritis
□ Heart Trouble	□ Numbness	□ Sinus Trouble	□ Rheumatic Fever
□ Diabetes	□ Asthma	□ Anemia	
□ Cancer_____			

Name of Primary Insurance Company _____

MY insurance covers chiropractic care ___ Yes _____No My copay is $_____ My deductible is $_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

INSURANCE QUESTIONAIRE

Ver Helst Chiropractic

The following questions are necessary so that we may properly file your insurance portion for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. **Patient Information**

Name: _____

Relationship to insured: □ Self □ Spouse □ Child □ Other

Patient Status (circle one): Single Married Employed FT Student PT Student Retired

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2. **Insured's Information**

Insured's Name (as it appears on the insurance card): _____

Insured's Address: _____

City: _____ State: _____ Zip: _____ Tel #: _____

Insured's Birthday: _____Insured's ID/Policy Number: _____

Insurance Plan Name: _____

Is there another health benefit plan? **Yes** ____ **No** ____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorized payment of medical benefits to Ver Helst Chiropractic for the serviced described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

Medicare Only

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? **Yes** ____ **No** ____
2. Are you entitled to Medicare because of End Stage Renal Disease? **Yes** ____ **No** ____
3. Is the illness or injury the result of an accident or illness that occurred at work? **Yes** ____ **No** ____
4. Is this illness or injury the result of an accident or other injury? **Yes** ____ **No** ____
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? **Yes** ____ **No** ____
6. Are you entitled to any benefits under the Federal Black Lung Program? **Yes** ____ **No** ____
7. Do you have a Medicare/Medigap Policy? **Yes** ____ **No** ____ Name of Company _____
8. Do you have a Medicare Supplement Policy (Policy provided by employer you retired from)? **Yes** ____ **No** ____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ Date: _____

Ver Helst Chiropractic Waiver Agreement

I concur with Ver Helst Chiropractic that the services he provided to me today are “medically necessary.” I understand that insurance companies, Wellmark Blue Cross/Blue Shield of Iowa and/or commercial insurance, do not pay for services that they determine to be not “medically necessary” and therefore may Deny payment for the services provided to me by Ver Helst Chiropractic. I agree to personally pay for services delivered to me by Ver Helst Chiropractic that are determined to be not “medically necessary” by any insurance company or Wellmark Blue Cross/Blue Shield of Iowa.

My signature below verifies that I am consulting Ver Helst Chiropractic today and give him Authority to diagnose and/or treat my condition, as he deems appropriate.

Welcome to our office! Have there been any slips, falls, accidents, or changes in your condition since your list visit? Please let the Dr. Kurt know this information.

Signature: _____ Date: _____