SPECTOR CHIROPRACTIC

Welcome to our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Privacy Practices:

I have received a copy of the Notice of Privacy Practices for Spector Chiropractic - ____________

patient initials

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

We may share your health information to:

- treat you
- collect payment
- run our office
- inform you about other services
- discuss your case with family
- do research
- include you in care classes
- thank you for referring other patients
- As a teaching institution, discuss your case with interns and consult with other colleagues

We may use your health information for:

- health and safety reasons
- reporting to law officials
- reporting victims of abuse
- court hearings and filings
- reporting to worker's compensation
- teaching / Instruction

You have the right to:

- request confidential communications
- request a list of whom we share your health information with
- request a copy of your health record (an additional fee may be involved)
- advise our management if you believe your privacy rights have been violated
- ask us to limit information sharing
- amend your protected health information

____

patient initials

These privacy practices are effective: January 1, 2011

For further information please contact: Ashley Spector, DC 972-746-0212

Consultation & Exam

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination, x-rays, and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service. ____________

Office Use Only:

____

Doctor's Signature # Date

I understand and agree to the above information:

____

Date

____

Print Name- patient or guardian

____

Signature- patient or guardian

Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

File # / Clinic ID	Date

1 PATIENT INFORMATION

last name			first name		m.i.
age	date of birth	social security #	gender	☐ male	☐ female
status	☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced				
street		city		state	zip
work phone / extension	home phone	cell phone	e-mail		
spouse or guardian last name		first name		m.i.	date of birth

2 EMERGENCY CONTACT

last name	first name	relationship	home phone	work phone	cell phone
last name	first name	relationship	home phone	work phone	cell phone

3 PATIENT EMPLOYMENT

employer name		occupation	
address street	city	state	zip

4 QUESTIONS

Who referred you to us?	
How did you hear about our clinic?	
Are you here because you were involved in a vehicle collision?	☐ yes ☐ no
Are you here because you were injured at your place of employment?	☐ yes ☐ no
Are you here because you were involved in another type of accident?	☐ yes ☐ no
Will you be using health insurance to supplement payment to our office*?	☐ yes ☐ no

* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

5 INSURANCE COVERAGE

types of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Work's Compensation ☐ TRICARE/CHAMPS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins. ID #	primary ins. group #
secondary insurance company	secondary ins. ID #	secondary ins. group #

I understand and agree to the following:

- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs
- There is no guarantee that my health insurance will pay for all or any part of my care
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred for services rendered
- All payments are due at the time services are rendered

patient or guardian signature

Date

Approved 7-7-08

6 INSURED'S INFORMATION

last name	first name	m.i.

street	city	state	zip

employer	age	date of birth	social security #	gender male female

Relationship to patient

Self Spouse Dependent Other ____

7 BENEFITS ASSIGNMENT & INFORMATION RELEASE

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

____

Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

______________________________________ ______________________________________

Patient or guardian signature Date

OFFICE USE ONLY:

Patient: last name	first name	m.i.	date of birth

FILE # **INTERN NAME & #** **DOC #** **POD#**

INSURANCE VERIFICATION

Person's name that you spoke to?

Last: First:

ID # Extension:

Does the plan have a **deductible?** yes no

Amount for an individual: ____________________

Amount for the family: ____________________

Amount currently met: ____________________

After deductible, what % of services do you cover? ____________

When does the deductible renew? ____________________

Does the patient have a **co-pay**? yes no

Amount for the co-pay: ____________________

What is the max. yearly **benefit**? yes no

Does the company **assign benefits** to the doctor? yes no

What is the **yearly visit cap**? ____________________

Are any **special forms** required to file claims? yes no

Auto Collision or **Personal Injury** case? yes no

Reported to the insurance company? yes no

Has an application for benefits been filed? yes no

Did the police write a report? yes no

Is auto or PI insurance primary? yes no

Agent name and contact info: ____________________

____

Workers' Comp case? yes no

Has the injury been reported? yes no

Name:

Title:

Is patient currently employed at place of injury? yes no

Name of person authorizing care: ____________________

____

Does the plan cover the following **services**?

Chiropractic Adjustments yes no

Modalities by a Chiropractor yes no

X-rays: ____________________ yes no

Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu. yes no

Orthotics, supports, pillows and Nutritional supplements? yes no

Other: ____________________ yes no

Address to send claims:

Approved 7-7-08

Pediatric Intake History

Please take a moment to fill out the following questions as accurately and truthfully as you are able. This information will greatly improve our ability to understand your goals for your child. If you need any assistance with any part, please don't hesitate to ask us for help.

Child's Name ______________________________ D.O.B ___ / ___ / ______

Sex M / F Parent/GuardianName(s)______________________________

Briefly describe your reasons for this evaluation.

____

____

What are your goals for your child's treatment?

____

____

B I R T H / N E W B O R N H I S T O R Y.

Weeks gestation ______ Birth weight ____ lbs ____ oz

How was your child delivered? Please circle. Vaginal C-Section

Were there complications during the pregnancy or delivery? Yes / No
(If yes, please describe.) ______________________________

____

Was there a need for O2/ventilator, tube feedings, surgery, NICU, or any special care following delivery?

Yes / No (If yes, please list.) ______________________________

M E D I C A L H I S T O R Y.

What specific medical conditions or diagnoses does your child have?

____

____

Please list all physicians involved in your child's care
____

Please list current medication
____

Please list any hospitalizations, surgeries, or diagnostic tests performed
____

____

Please list any allergies or precautions (ie: seizures) your child may have

____

D E V E L O P M E N TA L H I S T O R Y.

Please list ages that your child was able to: Roll ________ Sit alone ________
Crawl _________ Walk _________

Do you feel like your child is able to keep up with his or her peers of the same age?
Yes / No

If not, what limitations does your child have?

____

Does your child attend school? Yes / No

Has your child seen a chiropractor before? Yes / No
If yes, who:____
Has an immediate family member seen a chiropractor before? Yes / No

Does your child require any special equipment? Yes / No If yes, please describe.

____

Please use the space below to share any additional information you'd like us to
know about your child.

Parent/Guardian Signature ____________________________________ Date ____________