Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

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. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

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

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

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

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

FORTUNA CHIROPRACTIC CLINIC, LLC
DORIS J. FORTUNA, DC
EUGENE M. FORTUNA, DC

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GLADSTONE, MO 64118

(816) 468-5200
FAX (816) 468-5201

OFFICE POLICY

MISSING OR CHANGING APPOINTMENTS: We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, be sure to make up the missed appointment within one week.

PAYMENT OF BILLS: We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our financial manager immediately so new arrangements can be made. We prefer not to bill. Our office policy is that patients not have a cash personal balance beyond the cost of two (2) regular office visits. Insurance companies may exceed this amount. Also, any checks sent to your home by the insurance companies should be brought or sent to our office within three days. Please also send attached stub to indicate which services were paid. All accounts over 60 days will be subject to an interest rate of 1.5% per month. Failure of the patient to make payment of an overdue account or to otherwise communicate will result in prompt legal action.

NON INSURED PATIENTS: Services are to be paid for on the date they are rendered.

INSURED PATIENTS: Since by taking your insurance assignment we have to wait for payment, we ask that the co-insurance and/or deductible be paid as service is rendered. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.

You are required to sign an "Assignment of Benefits" form and any other assignment documents required by your insurance company on your first visit.

Our office does NOT guarantee that your insurance will pay. However, we will assist you in all paperwork needed.

Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

FORTUNA CHIROPRACTIC CLINIC, LLC
OFFICE POLICY (CONT.)

MEDICARE: We will bill Medicare and have you assign payment to us. We ask that the co-insurance and/or deductible be paid as service is rendered. Medicare does not cover the cost of x-rays. Also not covered are any therapies, supports, supplements, examinations or other services offered by this office. The only service covered by Medicare is manual manipulation of the spine. Your condition may require, in our judgment, more treatments than allowed by Medicare. If Medicare denies your claim for lack of medical necessity, the patient is responsible for payment.

AUTO ACCIDENT: Regardless of whom the responsible party is, a claim will be established with your health insurance and your auto insurance if you have medical payments or uninsured motorist's coverage. Contact your agent and inform him/her of your care in this office. It is your responsibility to supply us with the coverage information for the vehicle you were in.

If you are making a claim against the liability policy of another driver and you are represented by an attorney, we will also send a copy of the billing to your attorney.

Because of any possible delay of settlement, you will automatically receive a statement after you have been released from Dr. Fortuna's care for six months. At this time you will need to make arrangements to pay your outstanding bill.

WORKERS COMPENSATION: Workers Compensation covers all examination, treatment, and x-ray costs once treatment has been authorized. Your employer has the sole right to decide whether to grant authorization for treatment or not. Your supervisor on the job can also grant authorization.

Patients involved in a Workers Compensation case must bring signed authorization for treatment to our office. If signed authorization for treatment is not brought to our office on your second visit, you will be expected to pay for services rendered. If your compensation case involves a lawsuit, you and your lawyer must sign a lien for services rendered.

_____ _____

Signature **Date**

NAME OF PATIENT:_____

DATE _____

CONSENT TO TREATMENT OF MINOR CHILD

CONSENT TO TREATMENT OF ADULT WITH MEDICAL POWER OF ATTORNEY

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer treatment as he/she so deems necessary to _____ (Name of Patient).

Dated at _____ this _____ day of _____, 20_____.

PRINTED NAME OF PERSON AUTHORIZING TREATMENT:

_____

Signature_____

RELATIONSHIP TO PATIENT: _____

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? _____ (Please provide our office with a copy of the medical Power of Attorney).

Witnessed: _____