Patient Information

Name: _____ Date: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ May we contact you at work? ____Yes ____No

Email Address: _____
*Email will be used for appointment reminders and patient updates only. Dr. Daniel Bart will not share your email address with any third party. By filling out this address you agree to receive important chiropractic information.

Birth Date:_____ Social Security No: _____
Month / Day / Year

Gender: ____Male ____Female Females only: Are you pregnant? ___Yes ___No

Employer: _____ Occupation: _____

Marital Status: ____Married ____Single ____Widowed ____Divorced ____Separated

Emergency Contact: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Referred to this office by: _____ Are you currently a student? ____Yes ____No

Family Doctor: _____ Phone: _____

Who is responsible for your bill? ____Self ____Spouse ____Parent/Guardian ____Workers Comp

____Auto Insurance ____Personal Health Insurance ____Other

Have your ever received chiropractic care? ____Yes ____No If yes, when? _____

Reason for seeking care in the past: _____

Patient Case History

Major Complaint: _____

Location of Complaint: _____

Complaint began how? And when? _____

_____

What do you do that makes this problem worse? _____

What do you do that makes this problem better? _____

What does the complaint/pain feel like? ____Dull ____Aching ____Sharp ____Shooting ____Deep

____Burning ____Throbbing ____Nagging ____Other, explain:_____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain would be 10)

How frequently is your complaint present, how long does it last? _____

Before you began suffering with this problem, was there an earlier accident, injury, or condition that could have brought this about or be related to it? (Example: fall, auto injury, sports trauma, repetitive motion on the job) ____Yes ____No Describe: _____

_____

When this problem is at its worst compared to a time when you felt great, how does it interfere with: work / social life / hobbies / sports: _____

_____

What do you hope to do better once you regain your health? _____

_____

Previous treatments, surgeries, or care you've sought for your complaint: _____

_____

_____

What is your purpose for seeking chiropractic care?
____RELIEF *(I want to get out of pain for the least amount of time and money)*
____CORRECTION *(I want to fix the problem so it doesn't come back)*
____WELLNESS *(I want to make chiropractic part of a healthy lifestyle)*

History

Previous illnesses you have had in your life: _____

_____

_____

Previous injuries or traumas: _____

_____

_____

Have you ever broken any bones? ____Yes ____No If yes, which? _____

_____

List your allergies: _____

_____

Medications: _____ Reason for taking: _____

_____ _____

_____ _____

Surgeries: _____ Date: _____

_____ _____

_____ _____

Family Health History:
Associated health problems of relatives: _____

_____

Deaths in immediate family:
Cause of death: _____ Age at death: _____

_____ _____

_____ _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statues.

Patient or Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

FINANCIAL POLICY

Chiropractic care is covered by most insurance plans. Please read our policy as it applies to your particular situation.

Group or Individual Insurance:

After receiving your insurance information, we will be happy to call to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Actual plan benefits are determined when the claims are received by the insurance company. Ultimately, the patient is responsible for payment. Payment will be due by you at the time of service for any non-covered services, deductibles, co-insurance or co-pays.

Patients Without Insurance:

We request that 100% of the first visit be paid at the time of the visit. On subsequent visits, payment may be made at the time of service unless other arrangements have been made. Due to a savings on administrative costs, "Time of Service" payments are subject to a discount.

Worker's Compensation ("on the job" injury"):

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If you employer des not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, and fees and services are due immediately.

Automobile Accidents or Personal Injury:

Please notify your auto insurance carrier of your visit to our office immediately. Notify us immediately if an attorney is representing you. Although you are ultimately responsible for you bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for service are due immediately.

Medicare: Medicare is accepted by Dr. Bart. Please make note that Medicare does not pay for: Exams, X-rays, or Therapies. Medicare currently covers adjustments only.

I have read and understand the payment policy for Dr. Daniel Bart. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Bart and my insurance company. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as recommended by the doctor that fees will be due and payable immediately. Dr. Bart also reserves the right to bill for missed appointments at the full amount of the scheduled visit.

_____ _____

Patient's signature or Guardian Date

Patient Health Information and Consent to Treatment

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 HIPPA NOTICE that is available to you 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 (of 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 the 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. That patient may provide a written request to revoke consent at any time during care. This would not effect 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.

_____ _____

Patient Signature or Guardian Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the ability to express its maximum health potential.

We do not offer to diagnose or treat any disease of condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ *have read and fully understand the above statements.*
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature of Patient or Guardian Date