Dr. Nate Greenstein's Patient Intake Paperwork

Office Policy

Financial Information

- Payment is expected at the time the service(s) is/are rendered for private pay patients and patients with insurance including major medical, Medicare Advantage, and Medicare CMS Part B unless prior arrangements have been made. We accept cash, checks, Zelle® money transfers, MasterCard®, Visa®, Discover Card®, and the American Express Card®. Patient financing is available through Care Credit®.
- Two factors determine the cost for any particular visit. They are (1) the type of service(s) rendered and (2) the amount of time spent to perform the service(s).
- Your first visit usually includes a consultation and physical assessment/examination and starts at $200 for simple problem-solving to $600 for very complex problem-solving.
- Subsequent evaluations can cost from $200 to $600.
- Chiropractic manipulation fee is $95. Medicare CMS Part B patients pay from $25-$65.
- Diowave™ high power laser therapy with stealth Micro-Pulse™ technology is $150 for one 15-minute session. Multiple session packages are available and can be purchased at a discounted price.
- The fee for applied kinesiology is $95.
- Physical therapy can cost from $75 to $95 per procedure.
- Services and products offered: Functional medicine; dietary/nutritional counseling; nutritional supplementation, and orthopedic supports.
- Diagnostic tests offered: X-rays; CAT and MRI scans; ultrasound, nuclear medicine, and nerve conduction exams; laboratory and bone density tests.
- Failure to cancel or reschedule a missed appointment can result in a $75 charge.

Insurance Information

- **Major medical health insurance:** As an out-of-network provider, treatment is rendered without an assignment of benefits. Upon request, an insurance claim form/receipt for services rendered can be generated and submitted to your insurance carrier for processing and any reimbursement made will be sent to you, the patient, or insured.
- **Medicare CMS Part B health insurance:** As an out-of-network provider, treatment is rendered without an assignment of benefits. Spinal manipulation is the only reimbursable service. If medicare is your primary coverage, the reimbursement for the spinal manipulation will be approximately 80%; then, your secondary/supplemental policy reimbursement will be approximately 20%. In order for the spinal manipulation fee to be reimbursed, you must be experiencing an acute musculoskeletal or neurological condition. Maintenance care is not covered.
- **Medicare Advantage PPO and HMO insurance:** We do not participate in those health plans.
- **Automobile Insurance:** We do not treat automobile accident patients and usually accept an assignment of benefits. You are still responsible for all services rendered including and not limited to deductibles, copayments, and any non-covered services.
- **Workers Compensation Insurance:** We do not render treatment to patients covered by the workers compensation health insurance program.

If you have any questions, please do not hesitate to ask us.

By signing the office policy, I acknowledge reading and understanding the information as it pertains to me.

Patient's Printed Name: _____

Patient's/Legal Guardian's initials in lieu of Signature: _____

Date: _____

Legal Guardian's Printed Name: _____

Patient General Information

Date: _____ Birthday: _____ Age: _____

Legal Name Last: _____ First: _____ Middle: _____ Nickname: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Home Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ◯ M ◯ S ◯ W ◯ D or ◯ Separated Sex: ◯ M ◯ F

Occupation: _____ Employed by: _____

Employer's Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Physician: _____ Phone #: _____

Dentist: _____ Phone #: _____

Landlord: _____ Phone #: _____

Who may we contact in case of emergency?: _____ Relationship: _____ Phone #: _____

Who may we thank for referring you to us?: _____ Phone #: _____

List and describe any applicable insurance coverage:

_____

Patient Health History

What would you consider to be a positive outcome from treatment?: _____

What expectations do you have concerning treatment?: _____

What reservations do you have concerning treatment?: _____

How motivated are you in improving or overcoming your health problems, issues, and concerns?:

◯ 1 ◯ 2	◯ 3 ◯ 4	◯ 5 ◯ 6	◯ 7 ◯ 8	◯ 9 ◯ 10
Not Very Motivated	Somewhat Motivated	Fairly Motivated	Very Motivated	Extremely Motivated

List the major health problems, issues and concerns in your order of importance. Describe each one in detail, as to their location, nature, and occurrence.

If your health problems, issues, and concerns are related to an accident, give details of the accident (type, date, time of occurrence, and explain how the accident happened).

Describe all measures taken-to-date to improve your health problems, issues and concerns, including physicians seen, diagnostic tests performed, recommendations made, and treatments rendered.

List any signs and/or symptoms you may be experiencing or have experienced in each of the body systems.

Constitutional Symptoms (i.e. fever, weight loss): _____

Eyes: _____

Ears, Nose, Mouth & Throat: _____

Cardiovascular: _____

Respiratory: _____

Gastrointestinal: _____

Genitourinary: _____

Musculoskeletal: _____

Integumentary (skin and/or breast): _____

Neurological: _____

Psychiatric: _____

Endocrine (i.e. thyroid, adrenals): _____

Blood/Lymphatic: _____

Allergic/Immunologic: _____

Concerning your past history, list, briefly describe, and give the dates of **any** past illness, sickness, accident, injury, surgery, and dental work.

List and give the dosage of all prescription and non-prescription medications that you are **currently taking**, when you started them, the reason for them, and the results.

List and give the dosage of all prescription and non-prescription medications that you have **taken in the past**, when you started and stopped taking them, the reason for taking them, and the results.

List the nutritional supplements you are currently taking, including brand names, content, potency, dosage, and the reason for taking them.

Rate your **current** stress level

1 2 3 4 5 6 7 8 9 10

Extremely mild Severe

Rate your stress level for **the past five years**

1 2 3 4 5 6 7 8 9 10

Extremely mild Severe

List the amount and type consumed or used for each of the following:

Water: _____ Coffee: _____ Tea: _____

Soda: _____ Alcohol: _____ Tobacco: _____

Are you on a special diet or have specific eating habits? No Yes

If yes, explain: _____

Indicate your current eating habits:

How many meals per day?: _____ How many snacks per day?: _____

What are your snacks?: _____

Describe your average breakfast: _____

Describe your average lunch: _____

Describe your average dinner: _____

List the three **healthiest** foods you eat during an average week:

_____

List the three **worst** foods you eat during an average week:

_____

Do you experience any food cravings, sensitivities or allergies? No Yes

If yes, explain: _____

How many times a week do you eat fish?: _____

How many times a week do you eat raw nuts or seeds?: _____

How many times a week do you eat out?: _____

Are you in an exercise program?: ◯ No ◯ Yes

If yes, explain: _____

Do you wear orthotics?: ◯ No ◯ Yes Heel lifts?: ◯ No ◯ Yes Special shoes?: ◯ No ◯ Yes

List and explain your family health history (parents, grandparents, brothers, and sisters), for current and past major health problems. (e.g. heart disease, cancer)

Is there anything else that you'd like to add to your medical history? Please use the space below:

Please read, sign and date the following:

I completed the Patient General Information and Health History to the best of my knowledge. It's considered up-to-date, factual, and an accurate representation of my health. I will update my records with Dr. Nate's office when future changes occur.

Patient's Printed Name: _____ Date: _____

Legal Guardian's Printed Name: _____ Patient's / Legal Guardian's initials in lieu of Signature: _____