New Patient Welcome Form

Patient Information

Date_____ **Date of Birth**_____

Patient Name_____
First **M** **Last**

What do you prefer to be called? _____

Address _____

City _____ **State** _____ **Zip** _____

Patient SSN#_____

□ **Male** □ **Female** **Language** (If other than English)_____

Ethnicity (Mark one) □ **Hispanic or Latino** □ **Not Hispanic or Latino**

Race (Mark one or more) □ **American Indian or Alaska Native** □ **Asian** □ **White** □ **Black or African American** □ **Native Hawaiian or Other Pacific Islander**

Reminder Text/Call regarding future appointment □ **Yes** □ **No**

Cell Phone_____ **Cell Phone Carrier**_____

Home Phone_____ **E-mail**_____

Occupation _____

Employer/ School_____

Employer/ School Address _____

City _____ **State** _____ **Zip** _____

Employer/ School Phone_____

If Minor, Parent/Legal Guardian's Name_____

□ **Married** □ **Single** □ **Widowed** □ **Divorced** □ **Separated**

Spouse's Name_____

Spouse's Cell Phone _____

Spouse's Employer _____

How did you hear about us?_____

Health Insurance

Do you have a Flex Spending (FSA) or Health Savings (HSA) Account? □ **Y** □ **N**

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient □ **Self** □ **Spouse** □ **Child** □ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First **M** **Last**

Policy Holder's Date of Birth _____ **Sex** □ **Male** □ **Female**

Policy Holder's Address, City, State, Zip_____

Secondary Health Insurance

Insurance Company_____

Policy # _____**Group #**_____

Relationship to the patient □ **Self** □ **Spouse** □ **Child** □ **Other**

* If you selected "self" please stop here and proceed to the next section.

Policy Holder _____
First **M** **Last**

Policy Holder's Date of Birth _____ **Sex** □ **Male** □ **Female**

Policy Holder's Address, City, State, Zip_____

Emergency Contact

This must be someone NOT living in your household.

Name:_____**Relationship:**_____**Cell Phone:**_____ _____**Home Phone:**_____

Address:_____**City, State, Zip:**_____

Designation of Personal Representative

Name:_____**Relationship:**_____**Cell Phone:**_____ **Home Phone:**_____

Address:_____**City, State, Zip:**_____

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness & Chiropractic Center and it's physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature_____ **Date** _____

Print Guardian Name _____ **Relationship to Patient** _____

ALTERNATIVE WELLNESS
& CHIROPRACTIC CENTER

Height: _____ B/P: _____

Weight: _____ Pulse: _____

Office Use Only

Name:_____

I. HEALTH HISTORY

Do you smoke? ☐ Y ☐ N ☐ Social ☐ Quit

Current Medication:*_____

_____

☐ I will provide a list of my medications.

Allergies:*_____

_____

Medication Intolerance:*_____

_____

Name of Pediatrician and Other Doctors: _____

Date of Last Visit _____/_____/_____ Reason:_____

Complications During Pregnancy: ☐ No ☐ Yes Explain:_____

Ultrasounds During Pregnancy: ☐ No ☐ Yes How Many:_____

Medication During Pregnancy / Delivery ☐ No ☐ Yes List:_____

Cigarette/Alcohol Use During Pregnancy ☐ No ☐ Yes

Has any Doctor/Professional advised you to "Take the child to a Chiropractor": ☐ No ☐ Yes Name: _____

Please describe any past conditions and treatment received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history you want us to know?_____

II. REVIEW OF SYSTEMS

(Check all that apply)

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Vision Problems
☐	☐	Ear Infections	☐	☐	Sleeping Problems
☐	☐	Colic	☐	☐	Growing Pains
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Temper Tantrums
☐	☐	Recurring Fevers	☐	☐	ADHD
☐	☐	Digestive problems	☐	☐	Scoliosis
☐	☐	Chronic Colds/Sinus	☐	☐	Ever Needed Stitches
☐	☐	Other_____			

III. REASONS FOR SEEKING CARE

Present Complaints

1. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

2. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

3. _____**How long has this been an issue?**_____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in morning ☐ Worse in evening ☐ Pain radiates to_____

4. What makes it better?_____

5. What makes it worse?_____

6. What Doctor's have you seen for this?_____

7. Type of treatment:_____

8. Results:_____

Rate your pain 0 to 10, ten being the worst

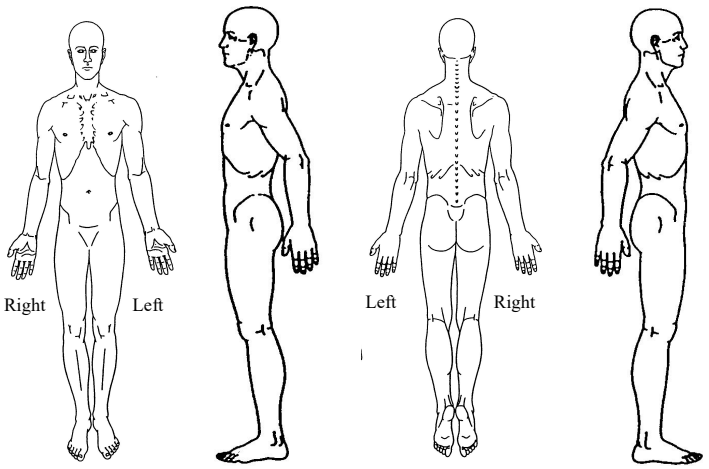
Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back, Hip Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain _____
0 1 2 3 4 5 6 7 8 9 10

Mark <u>ALL</u> areas of pain on figures below



IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature_____ Date _____

(Office Use Only)

The above health history questionnaire was reviewed by _____(Physician) Date _____

Patient Name:

We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You.

Covered/Non-Covered Services

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Rehabilitation codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our clinic will not quote insurance benefits; therefore, you are encouraged to contact your health plan. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

New Patient Promo: New patients are eligible for a Consultation, Exam, and X-rays, if needed for $_____. Which is paid in full due at time of service. This promo **does not** include a chiropractic adjustment. Promo excludes Medicare and Medicaid.

Illinois Medicaid: This office **does not** accept Illinois Medicaid. I agree that I do not receive Illinois Medicaid health coverage. Initials_____

____PLEASE INITIAL AFTER READING

Billing and Payments

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. This clinic will provide any necessary reports or required information to aid in insurance reimbursement of services. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do.

All co-pays and known co-insurance amounts are due at the time of service.

In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction.

Patient statements mailed out bi-monthly for previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our clinic to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments.

All accounts with patient portion balance showing no patient payment activity will be charged a 1.5% monthly late payment fee, for each month no payment is made on the account.

All outstanding unpaid patient account balances over $100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

____PLEASE INITIAL AFTER READING

Patient Name:

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this clinic. If your insurance carrier sends payment to you for services incurred in this clinic, you agree to send or bring those payments to this clinic upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

____PLEASE INITIAL AFTER READING

Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards and text messages are available to help you save the date and time of your appointments.

Our patient's, team and doctor's time is valuable, and we wish to provide every patient with an excellent experience. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. Please provide us the courtesy of a **24 hour cancellation** or change notice if you are unable to keep your appointment time.

On your third no-show occurrence, there will be a **$25 charge** to your account. After three consecutive no-show occurrences, the clinic may elect to terminate our relationship with you.

____PLEASE INITIAL AFTER READING

Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Iowa State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our clinic and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services. We thank you for being a patient at our clinic.

____PLEASE INITIAL AFTER READING

Release of Information

If we bill your insurance company, and you insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this clinic to release the medical information necessary to process your claim.

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

____PLEASE INITIAL AFTER READING

Pregnancy Release

I certify that I am not pregnant at this time, and I agree to indemnify Alternative Wellness & Chiropractic Center for any medical complications which may result from radiographic studies performed on myself or unborn fetus.

____PLEASE INITIAL AFTER READING

Patient Name:

Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic 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 used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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 service 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 the 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. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

____PLEASE INITIAL AFTER READING

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to obtain your informed consent before starting treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with stroke; strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one to ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same change as a normal dose of aspirin or Tylenol causing death.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. When osteoporosis, degenerative disc or other abnormality is detected, this clinic will proceed with extra caution.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Womboldt checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

Doctor Signature:_____ Date:_____