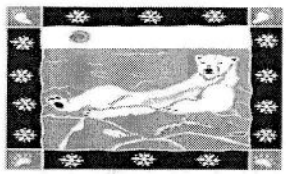
Arctic Chiropractic Kodiak



PATIENT INFORMATION

Date: _____ Referred by? _____ Is this visit due to an accident? **YES / NO**

Full Name:_____ DOB:_____ Age:_____ Sex:_____ SS#:_____/_____/_____
Please Print M/F

Home Phone: _____ Cell Phone:_____ Marital Status:_____ M/S/D/W

Mailing Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Company Name:_____ Phone #:_____

Spouse's Name:_____ Spouse's DOB:_____ Sponsor I.D. (Tricare): _____

Do you have insurance? **Yes / No** If "yes" Ins. Name: _____**(please present card to office staff)**

Who should we call in case of emergency:_____ _____ _____
Full Name Phone # Relationship

May we have your email?_____

Personal Medical History (Please use a check mark under Yes or No if relevant to your medical history.)

	Yes	No
High Blood Pressure		
Polio		
Tuberculosis		
Cancer		
Heart Trouble		
Diabetes		
Contagious Diseases		

	Yes	No
Muscular Dystrophy		
Convulsions		
Epilepsy		
Concussion		
Hepatitis		
Venereal Disease		
Blood Clots		

	Yes	No
Multiple Sclerosis		
Rheumatic Fever		
Scarlet Fever		
Nervousness		
Asthma		
Dizziness		
Arthritis		

	Yes	No
Digestive Disorders		
German Measles		
Allergies		
Backaches		
Numbness		
Other:		
(Woman Only) Pregnant		

Briefly describe symptoms you are having:_____
When did symptoms appear _____
Is condition getting worse? Y / N **Type of Pain:** -Sharp –Dull –Throbbing –Numbness –Aching –Shooting -Burning –Tingling – Cramps Stiffness –Swelling –Other: _____
How often do you have the pain? _____
Is it constant or does it come and go? _____ **Does it interfere with** work / sleep / daily routine / recreation
Activities or movements that are painful to perform: -sitting –standing –walking –bending –lying down
List operations and dates: _____

Date of last physical exam? _____

Are you currently being treated by a physician? **Yes / No, If** "yes" by whom: _____
Are you currently taking medication? **Yes / No** If "yes" what kind: _____
List allergies you have to medication/medical supplies: _____

Continued

Clinic Policies

HIPAA Privacy Practices – Patient Acknowledgement of Receipt of Notice

I hereby acknowledge receipt of the Notice of Privacy Practices regarding my health information. I have been informed and understand the way in which my health information shall be maintained, utilized and disclosed by the Clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this notice at any time by contacting Arctic Chiropractic at (907) 486-4042. My signature herein below constitutes full acknowledgement that I have been furnished a copy from the Arctic Chiropractic & Physical Medicine Kodiak.

Cancellation Policy

We ask that you give us 24-hour notice of cancellation for massage appointments. If we do not receive 24-hour notice you will be responsible for paying the therapist a fee of $65. Your insurance company will not be billed for this, it will be solely your responsibility. This payment goes directly to the therapist. If you are a patient receiving treatment for a worker's comp or personal injury accident, the fee will be billed directly to you.

Assignment & Release

By signing below, I authorize Arctic Chiropractic & Physical Medicine to release medical records required by my insurance company(s) or any referring health facility (KANA, KCHC, KIAC, VA). I authorize my insurance company(s) to pay benefits directly to Arctic Chiropractic & Physical Medicine. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.

Financial Policy

I understand that I am responsible for all charges incurred by myself at the Arctic Chiropractic & Physical Medicine. I understand that my insurance company may not pay for charges according to my benefit plan. I will be responsible for any co-pay, co-insurance, deductible, and non-covered items or services deemed not medically necessary by my insurance company. I will pay my patient portion balance in a timely manner.

Financial Responsibility

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that should I choose not to process my treatment through insurance that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctor at Arctic Chiropractic & Physical Medicine Kodiak and whomever they may designate as their assistants to administer treatment as they deem necessary. I acknowledge that the benefits quoted to me by staff at Arctic Chiropractic Kodiak are not a guarantee that my insurance will process or pay as stated. I am also aware that these benefits quoted to me can change at any time for any reason that the insurance deems and that while the clinic staff tries to keep track of all visits used, ultimately it is my sole responsibility to keep track of this information. I realize that if I exceed the allowed visit amount that I will be responsible for all charges. At any time, my insurance company may request a copy of my medical records. If upon review of those records, they find my treatment to be not medically necessary, I may be responsible for those charges.

CONSENT FOR TREATMENT

Dear Patient:

Chiropractic, Physical Therapy, and Massage involve the use of many different types of physical evaluation and treatment. As with all forms of medical treatment there are benefits and risks involved in undertaking any type of care. Since the physical responses to a specific treatment can vary greatly from person to person, it is not always possible to accurately predict a patient's exact response to treatment. Nor can we guarantee that our treatments will help improve the condition(s) you are seeking treatment for. Additionally, if during care, we encounter unusual findings, we will advise you of those findings and recommend further testing or refer you out to another health professional. There is also a risk that your treatment may cause pain, injury, or aggravation of a pre-existing condition (either diagnosed or undiagnosed). Therapeutic exercises, spinal manipulation, and myofascial release are essential parts of most of the types of treatment we offer here at Arctic Chiropractic & Physical Medicine Kodiak. It is not unusual to be sore after your first few treatments. You have the right to ask any of your providers what type of treatment they are planning based on your history, diagnosis, symptoms, and evaluation findings. You have the right to decline any portion of your treatment at any time during your treatment session.

_____

Print Legal Name **Patient's (Parent/Guardian) Signature**

Consent to evaluate and adjust a minor child

I,_____, being the parent or legal guardian of _____

have read and fully understand the above Informed Consent and hereby grant permission for my child to receive Chiropractic care, Physical Therapy, or Massage Therapy.