Confidential Patient Registration & History

Patient Information

Date_____
Name_____
Address_____
City_____State_____Zip_____
Sex M__ F__ Age ____ Birthdate _____
Single___ Married__ Widowed__ Separated__ Divorced__
Children____ SS#_____
Occupation_____
Employer_____
Employer Address_____
Employer Phone_____
Spouse/Guardian_____
Birthdate_____ SS#_____
Employer_____
How did you hear about this office?_____
Email_____

Phone Numbers

Home_____ Work_____ ext_____
Cell_____ Best time/place to call_____

In Case of Emergency Contact:

Name_____ Relationship_____
Home_____Work/Cell_____

Insurance

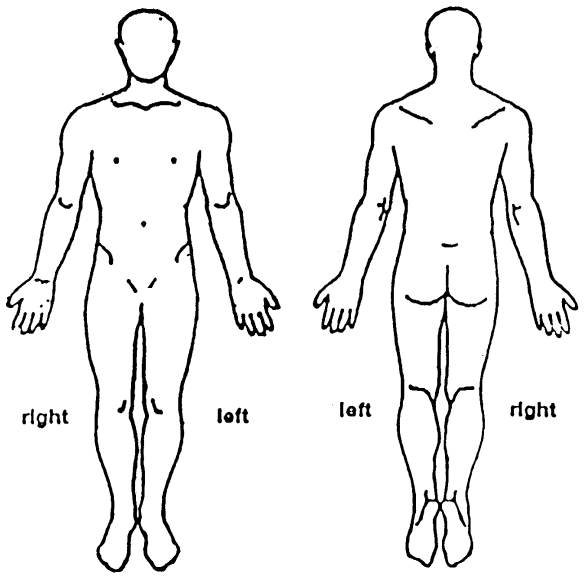
Who is responsible for this account?_____
Relationship to Patient_____
Insurance Company_____
Group & ID #_____
Is there additional insurance?_____
Subscriber's Name_____
Birthdate_____ SS#_____
Relationship to Patient_____
Insurance Company_____
Group & ID #_____

ASSIGNMENT & RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with above named company, and assign directly to Dr. Lisa Day all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature Date

Patient Condition

Reason for visit_____
When did your symptoms appear?_____
Is this condition getting progressively worse? Y N unsure
Mark an X on the picture where you have pain/numbness/tingling/etc.
Rate the severity of your pain from 1 (low) to 10 (extreme) _____
Type of pain: __sharp __dull __throbbing __numbness __aching
__shooting __burning __tingling __cramps __stiffness __other
How often do you have this pain?_____
Is the pain constant or does it come & go? _____
Does it interfere with: __work __sleep __daily routine __recreation
What aggravates your condition?_____
What gives you relief?_____
Have you noticed changes in other body functions? Y N Explain
_____
Have you ever had the same pain in the past? Y N Explain
_____



DAY CHIROPRACTIC - Dr Lisa Day - 2316 230th St Ste701 Ames, IA 50014 - ph 515-233-9464 fax 515-292-5551

Health History

What other treatment have you had for your condition? ___ Medication ___ Surgery ___ Physical Therapy
___ Chiropractic services ___ None ___ Other _____

Name & address of other doctor(s) who treated you for your condition_____

Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-ray _____ Chest X-ray _____
Dental X-ray _____ MRI/CT/Bone Scan _____ Blood Test _____ Urine Test _____

Injuries/Surgeries you have had: (please give description & date)

Falls & Head Injuries_____
Broken Bones & Dislocations_____
Accidents_____
Surgeries_____

EXERCISE	WORK ACTIVITY	HABITS	
___ none	___ sitting	___ smoking	packs/day_____
___ moderate	___ standing	___ alcohol	drinks/week_____
___ daily	___ light labor	___ coffee/caffeine	cups/day_____
___ heavy	___ heavy labor	___ high stress	reason_____

List other activities/hobbies:_____

Your diet is: ___ Balanced ___ Fair ___ Poor ___ Excessive ___ Restricted

In what position do you usually sleep & how well?_____

Females - Are you pregnant? Y N Due Date_____ / Menstrual Problems?_____

CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV	Emphysema	Miscarriage	Scarlet Fever
Alcoholism	Epilepsy	Mononucleosis	Stroke
Allergy Shots	Fractures	Multiple Sclerosis	Suicide Attempt
Anemia	Glaucoma	Mumps	Thyroid Problems
Anorexia	Goiter	Osteoporosis	Tonsillitis
Appendicitis	Gonorrhea	Pacemaker	Tuberculosis
Arthritis	Gout	Parkinson's	Tumors/Growths
Asthma	Heart Disease	Pinched Nerve	Typhoid Fever
Blood Disorder	Hepatitis	Pneumonia	Ulcers
Breast Lump	Herniated Disc	Polio	Urinary Problems
Bronchitis	Herpes	Prostate Problem	Vaginal Infections
Bulimia	High Cholesterol	Prosthesis	Venereal Disease
Cancer	Kidney Disease	Psychiatric Care	Whooping Cough
Cataracts	Liver Disease	Rheumatoid Arthritis	Other _____
Chicken Pox	Measles	Rheumatic Fever	_____
Diabetes	Migraines		

MEDICATIONS VITAMINS/HERBS/MINERALS

_____

_____

ALLERGIES_____

Medical Doctor _____ OB/Gyn _____ Dentist _____

Pharmacy Name & Phone _____

OFFICE POLICIES/FEE INFORMATION

In order to keep all patients informed about every phase of their care program, we feel it is necessary that you be informed **BEFOREHAND** of the fees and policies at **Day Chiropractic**.

All fees are payable at the time services are rendered. Cash, check, Visa and MasterCard are accepted.

The INITIAL OFFICE VISIT may consist of the following services:

Case History and Consultation	N/C
Physical Signs (Weight, Blood Pressure, etc.)	N/C
X-rays (full spine A-P and Lateral)	$100.00
Chiropractic Exam:	
Initial Exam/Re-exams	$50.00

A **routine office visit** is determined by the following:

98940	Spinal Adjustment (1-2 Regions)	$40.00
98941	Spinal Adjustment (3-4 Regions)	$45.00
98940	Medicare Allowable Charge (1-2 Regions)	$29.00
98941	Medicare Allowable Charge (3-4 Regions)	$42.00
98943	Extremity Adjustment	$30.00

If your case necessitates more extensive evaluation procedures, there may be additional charges.

Vitamin supplements, heel lifts, and orthopedic supports are available for order & purchase.

Patient care schedules are devised individually for each patient. We respectfully request that you adhere to your appointment scheduled time. If you reschedule an appointment it must be made up within 7 days, in order to stay on your personalized care schedule to obtain the results for which you and Dr. Day are striving.

As a courtesy to you, we will supply 2 itemized statements upon request per year at no charge. For any additional requests there will be a $5.00 charge.

It is a policy of this office to keep stress levels down for our patients so they may benefit from their care as much as possible. Therefore, we request that you keep your account current. Meaning, there are to be no personal balances over $150.00 from one week to the next.

Please be advised: We will charge $25.00 for all returned checks for whatever reason.

Your records are a permanent file at this office. You may request a copy via a signed release form, of some items, or request transfer copy of records and some pertinent information for corresponding care at another facility. X-rays can be mailed out and then returned in a timely manner.

INSURANCE: We do accept insurance assignment with many insurance companies. Typically you will pay your co-pay as services are rendered, and your insurance company will pay us the difference according to your policy. Once the allowances for care have been reached, you may continue care by paying out of pocket.

MEDICARE: We are **NOT** participating providers for Medicare. This means that you will pay us as services are rendered and Medicare will reimburse you according to your policy – so you still get the benefit.

MEDICAID (Title XIX) patients are required to pay their **co-pays at each visit**, as well as pay for their exams and x-rays as they are rendered, **$25 fee**. (As required, we do accept insurance assignment for Title XIX.)

A major reason for the fine reputation and rapid growth of our office is the highly enthusiastic recommendation of our satisfied patients. We know that you, too, will want to help others regain their lost health by telling them about Chiropractic.

Please discuss with us promptly and frankly any questions you may have regarding your care. We make every effort to avoid misunderstandings and to preserve your friendship.

Patient Signature: _____ 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 toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any 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 adjustment of the spine to relieve disruption to the nervous system and health.
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 transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

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

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 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 & health. Our only method is specific adjusting to correct vertebral subluxations.

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

Consent to evaluate and adjust a minor child

I, _____ (print name) being the parent or legal guardian of _____ (child's name) have read and fully understand the above terms of acceptance and hereby grant permission of my child to receive chiropractic care.

_____ (signature) _____ (date)

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ (signature) _____ (date)

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Day Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and medical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Day Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Day Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Day Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and *I consent to such disclosure for these permitted uses*, including disclosures via fax.

I fully understand and accept the terms of the consent.

Signed_____ Date_____

I authorize _____ access to some of my account/authority to schedule.