Pirkl chiropractic

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NEW PATIENT INTAKE FORM

Today's Date			
PATIENT INFORMATION			
Patient's Last Name:	First:		Middle Initial:
Address: City: State: Zip:			Marital Status: (circle one) M S D W
SSN:	Date of Birth:	Are you a referral? (circle one) Yes No	From whom?
Home Phone: Cell Phone:		Employer:	
Work Phone: Email:		Emergency Contact: Phone Number:	

INSURANCE INFORMATION	
Insurance Company: ID #: Group #	(only fill out if primary is Medicare) 2nd Insurance ID #: Grp #
Insured/Policy Holder (name):	Insured/Policy Holder (name):
Insured's Date of Birth:	Insured's Date of Birth:
Insured's SSN:	Insured's SSN:
Patient relation to Insured: (circle one) self spouse child	Patient relation to Insured: (circle c one) self spouse child

ACCIDENT INFORMATION			
Is condition due to an accident?	yes	no	Attorney's Name:
Date:			Attorney's Address:
Type of accident: (circle one)	auto	WC	
Have you reported the accident?	yes	no	Attorney's Phone #:
Claim #:			

Assignment and Release

By signing below, I certify the following (as applicable):

- I assign directly to Pirkl Chiropractic all insurance benefits payable for services rendered.
- I authorize the use of my signature on all insurance submissions.
- I authorize Pirkl Chiropractic to release patient health information required to process my claims.
- I understand I am fully financially responsible for all charges whether or not paid by insurance.

Signature of Patient or Parent/Gaurdian _____ Date _____

PATIENT CONDITION

Reason for visit _____

When did symptoms appear?_____

Is condition getting worse? Yes No

Is pain (circle all that apply) …

Daily constant frequent intermittent

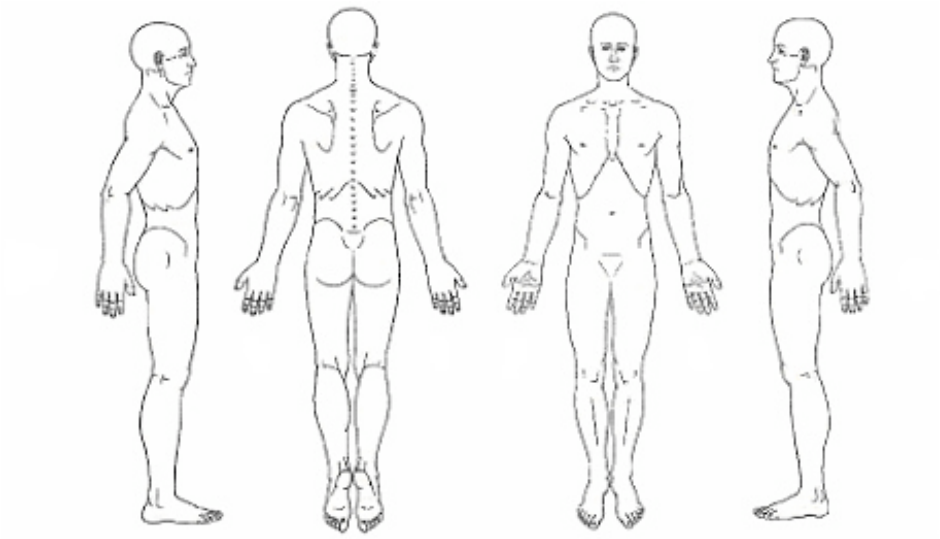
Does it interfere with activity? Yes No

Type of pain (circle all that apply) sharp dull

Tingling throbbing cramping numb stiff

Shooting other _____

CIRCLE AREAS OF PAIN



BILLING PROCEDURES

TO INSURANCE PATIENTS: It is YOUR responsibility to provide accurate information about your health insurance and submit secondary claims. We will ONLY submit claims to your primary insurance, and patients with Medicare as a primary insurance automatically roll-over to secondary. For your convenience, we generate and send claims off promptly and electronically. It is YOUR responsibility to keep track of your benefits, and any limits or maxes per your plan. If your insurance denies your claim for any reason, you are ultimately responsible for that service.

TO MEDICARE PATIENTS: Medicare pays only for the adjustment procedure. Exams, xrays and any other therapies are not covered.

TO CASH PATIENTS: As a cash paying patient you receive a 20% discount on all services if you pay the same day of service. This also applies to those with poor chiropractic benefits/high deductible. YOU CAN NOT, however, use both insurance AND cash discounts.

TO ALL PATIENTS: All patients are ultimately responsible for the payment of their services. Billing is done monthly for all outstanding balances. Unpaid balances past 60 days are automatically assessed a late fee of $25 per month and will eventually be sent to collections if no other financial arrangements are made.

Signature _____ Date _____

Spinal Care Treatment Options

To the patient: Please read carefully prior to signing this document. It is important that you understand the following information. Please ask questions before you sign if anything is unclear.

The nature of the chiropractic adjustment
The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy and I will use that procedure to treat you. I use my hands in such a way as to move your joints that may cause an audible pop or click, much as you have experienced when you "crack" your knuckles. You may sense a movement in your spine. Chiropractic manipulation is a safe and effective method of care for spinal pain.

Analysis/Examination/Treatment
As a part of our care, you are consenting to the following:

Spinal manipulation	palpation	vital signs	range of motion testing
Orthopedic testing	basic neurologic testing	muscle strength testing	postural analysis
Hot/cold therapy	acupuncture	massage therapy	other _____

Benefits of chiropractic care
Of the millions of patients who receive chiropractic care every year, the Gallup organization found that 9/10 felt treatment was effective. In addition, these patients were 3 times more satisfied with their chiropractic care than with other types of health care for similar conditions.

The material risks inherent in chiropractic adjustment
As with any health-care procedure, there are certain complications which may arise. These include but are not limited to fractures, disc injuries, dislocations, and muscle strain. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complication including stroke. I make every effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring
Serious complications are fewer than 1-5 cases per million treatments. Muscle soreness is not uncommon, but is usually transient and mild in severity.

The risks attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduced mobility, which may set up a pain reaction, further reducing mobility over time. This process may complicate treatment, making is more costly.

Please ensure you understand the above information
I have read ___ the above explanation of chiropractic adjustment and related treatment. I have discussed it with Dr. Pirkl and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. I hereby give my consent to receive that treatment.

_____ _____
Patient's Name Doctor's Name

_____ _____
Patient's Signature Date Doctor' Signature Date

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

At Pirkl Chiropractic, we want to provide you with the best possible care. There are services that I feel are necessary or in your best interest for the treatment of your condition and maintenance of good health. Some of these services may not be covered by your insurance. You will be expected to pay for those services in full.

Covered services traditionally include:

- Treatment that has the potential to significantly improve a clinical condition
- Limited treatment of symptoms, flare-ups, or exacerbations where a permanent conditions exists

Services NOT covered include

- Some diagnostic services
- Some therapeutic services
- Some durable medical products (braces, ice packs, tens, STIM)

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I am fully responsible for the total billed charge(s) related to non-covered services.

Patient Signature: _____ Date: _____

NON-COVERED SERVICES TREATMENT PLAN DISCLOSURE FORM

I have chosen to receive the following care that is not covered by my health plan and I agree to pay the full charge(s) for the following services:

# of visits and date of last visit (expected) _____

Description of services _____

Approximate Cost _____

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I understand that by signing this form, I am fully responsible for the total billed charge(s) related to non-covered services.

Patient Signature: _____ Date: _____

MEDICAL LIEN

I am not currently with legal representation for anything pertaining to my Chiropractic care today.

Patient Signature: _____ Date: _____

OR

I hereby authorize and direct you, my attorney, to pay directly to Pirkl Chiropractic such sums as may be due and owing for medical service rendered to me/my dependent by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Pirkl Chiropractic.

I hereby further give a lien on my case to Pirkl Chiropractic against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to Pirkl Chiropractic for all medical bills submitted by them for service rendered to me/my dependent, and that this agreement is made solely for Pirkl Chiropractic's protection and in consideration of the their awaiting payment.

I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____