



DOCTOR JOE'S CHIROPRACTIC CENTER

1337 E 17th St, Idaho Falls, ID 83404 208-522-1026 Fax 208-522-1208 www.doctorjoecanhelp.com

APPLICATION FOR CARE

The following information is needed in order to better serve you. If you need help please ask the receptionist.
PLEASE PRINT AND **ANSWER ALL OF THE QUESTIONS** – THANK YOU.

Today's Date _____

Name _____ Social Security # _____

Home Phone _____ Cell Phone _____

Email: _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Sex Female Male Birthday _____ Number of Children _____

Marital Status: Single Married Widowed Divorced Partnered Separated

Your Employer / School _____ Type of Work / Major _____

Employer Address _____ City _____ State _____ Zip _____

Do you have Medicare? Yes No Insurance? Yes No Medicaid? Yes No

Name of Spouse/Partner/Parent _____ Their Birthday _____

Spouse/Partner/Parent Employed / School _____ Type of Work / Major _____

Employer/School Address _____ City _____ State _____ Zip _____

How did you find out about us? _____ Spouse/Partner have insurance at work? Yes No

Current Health Condition (Please answer all of the questions)

Have you ever had chiropractic care before? Yes No If yes, who and when? _____

Describe your symptoms _____

How did your condition/pain occur? *(be as specific as possible)* _____

When did your condition/symptoms/pain first appear? *(please give a specific date)* _____

Who have you seen for your current symptoms? _____ When? _____

How often do you experience your symptoms? Constantly (76 – 100% of the day) Frequently (51 – 75% of the day)
 Occasionally (26 – 50% of the day) Intermittently (0 – 25% of the day)

Have you ever had this problem before? Yes No If so, when and what treatment? _____

Did you hear or feel any snapping, popping, tearing, etc when this began? Yes No Describe _____

Since the onset of your problem, is it: Getting worse Staying the same Slow to improve Getting Better

During the past 4 weeks, how much has the pain interfered with work (including both work outside the home, housework, schoolwork)?
 Not at all A little bit Moderately Quite a bit Extremely

During the past 4 weeks, how much has the pain interfered with social activities?
 Not at all A little bit Moderately Quite a bit Extremely

When is it worse? Morning Afternoon Evening It's the same day and night

Does the condition/symptom/pain radiate? Yes No If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Kind of Pain: numbness tingling weakness aching burning dull
(Check All that Apply) sharp shooting throbbing Other _____

What activities or positions **AGGRAVATE** (make worse) your condition?

- bending coughing getting up/down driving lifting lying down
 reaching sitting sneezing standing straining at stool
 turning head twisting walking Other _____

What activities or positions **RELIEVE** (feel better) your condition?

- heat ice lying down medication sitting standing
 stretching Other _____

If this is an accident, did it happen at: Home Auto Work Other _____

For Women Only

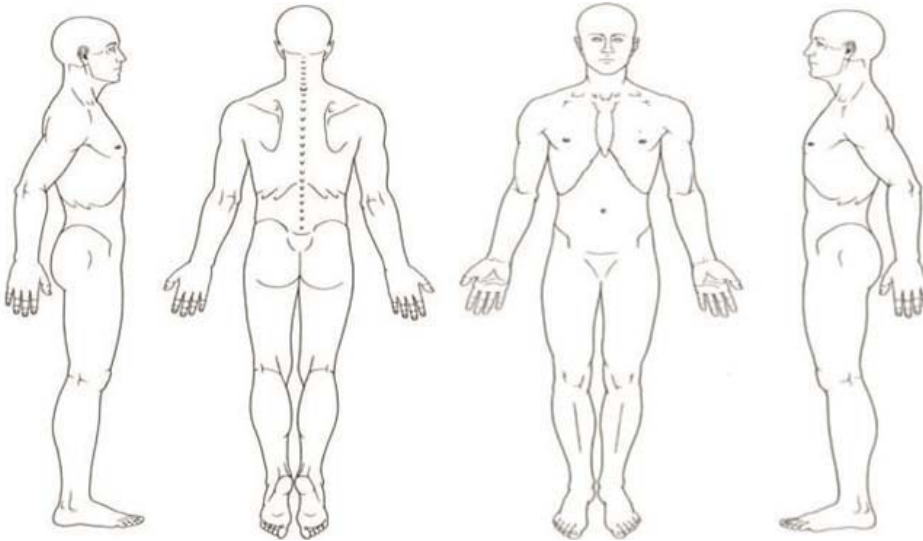
Do you currently or have you ever used birth control? Yes No If yes, what brand(s), dosage, when, and for how long? _____

Do you currently or have you ever taken hormone replacement medication? Yes No If yes, what brand(s), dosage, when, and for how long? _____

Are you currently pregnant, or do you think you may be pregnant? Yes No If yes, for how many weeks? _____

COMPLETE THESE DIAGRAMS

→ **Please mark the exact location of your pain** on the diagram below using the symbols provided on the right side bar.



Numbness ###	Sharp ///
Tingling +++	Shooting \\
Weakness ***	Throbbing 888
Aching ^^^	Radiating vvv
Burning xxx	Dull 000

→ **Now rate the level of pain.** Zero (0) being no pain at all, and ten (10) being the worst pain imaginable

EXAMPLE – EXAMPLE -- EXAMPLE -- EXAMPLE -- EXAMPLE – EXAMPLE -- EXAMPLE -- EXAMPLE												
Area of body: <u>Neck</u>	Rate the Level of Pain	<u>X</u>										
		0	1	2	3	4	5	6	7	8	9	10
(Example of Neck pain rated at a 7)		No Pain					Worst Pain Imaginable					

Area of body: _____ Rate the Level of Pain _____
 0 1 2 3 4 5 6 7 8 9 10

Area of body: _____ Rate the Level of Pain _____
 0 1 2 3 4 5 6 7 8 9 10

Area of body: _____ Rate the Level of Pain _____
 0 1 2 3 4 5 6 7 8 9 10

Financial Policy

- 1) All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff
- 2) This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.

Insurance

- 3) If you have insurance, we will gladly accept assignment with the following exceptions and regulations provided we have prior certification from your insurance company.
- 4) We accept assignment for the initial phase of your treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been released from initial active care and placed on maintenance care, we will continue to file your insurance, however insurance will not pay for maintenance care.
- 5) We accept assignment as a courtesy to you; ultimately you are responsible for your entire bill should your insurance company not pay any of the charges for any reason. We are not a mediator between you and your insurance company and we will not enter into any disputes, as your contract is between you and your insurance company.
- 6) If you should receive a check from your insurance company during our billing that should have come to us to pay your account, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done by the insurance company, we will issue a credit to your account if a balance is due.
- 7) Any services not covered by coverage by your insurance may be your responsibility.
- 8) This office will resubmit a claim one time only. We will not enter into dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely manner.

How payment will be made today – Please Initial:

_____ Cash _____ Worker’s Comp. _____ Automobile Insurance Policy
 _____ Check _____ Credit Card _____ Insurance

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. Should collections become necessary, the responsible party agrees to pay an additional 30% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments and physical therapy modalities Signature below is an agreement to the above:

Patient Signature  _____ Date _____

Guardian/Responsible Party Signature _____ Date _____

HIPAA Acknowledgement Form

I hereby give consent to Doctor Joe's Chiropractic Center for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice. I have read the HIPAA Notice of Privacy Practices document from Doctor Joe’s Chiropractic Center and understand and agree with what I have read. I am aware that I can ask this office at any time for a copy of their HIPAA Notice of Privacy Practice document and that it may change from time to time for updates and amendments. I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods
(Please check all applicable ways in which we may contact you)

- Home phone Cell phone Work Phone U.S. Mail Email

Patient Signature  _____ Date _____

Signature of Parent/Guardian _____ Date _____

Informed Consent to Chiropractic Care
Doctor Joe's Chiropractic Center Dr. Joe Nalbone, DC
1337 E 17th St Idaho Falls ID 83404 208-522-1026

Though the risks are small, as with other physician treatment methods, we feel that an informed consent is necessary to allow a patient to know the risks and to take those risks into consideration when deciding to have or not have the recommended chiropractic care. Chiropractic adjustments and therapeutic procedures (including spinal and/or extremity adjustments, heat/cold application, mechanical traction, adjunct physical therapy, and manual muscle therapy) are considered safe and effective methods of care. However, any procedure intended to help may have complications. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. While the chances of experiencing complications are small, it is the ethical practice of Dr. Joe Nalbone, D.C. and the staff at Doctor Joe's Chiropractic Center to inform every patient about them. Risks include, but are not limited to, soreness, sprains, fractures, disc injury, strokes, dislocations, and increased symptoms or no improvement .

I have the opportunity to discuss with the doctor and/or staff members the purpose and benefit of chiropractic adjustments and other treatments. I understand that I have the right to ask questions about chiropractic care and to inform myself of the risks and benefits of care before care begins and at any time during my treatment plan. Some of the alternatives to chiropractic include over the counter medication, prescription medication, physical therapy, surgery, or to do nothing.

I hereby request and consent to the performance of chiropractic adjustments throughout my spine and/or other joints and extremities such as, but not limited to, feet, toes, ankle, knee, hip, shoulder, elbow, wrist, fingers, cranium, and to use other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or patient named below, for whom I am legally responsible) by Dr. Joe Nalbone, DC and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Joe Nalbone, DC.

I also certify that no guarantee or assurance has been made as to the result that may be obtained. I have read this form and understand that I can ask questions at any time regarding this consent form.

I acknowledge that I have been informed and have had, and will have, the opportunity to discuss with my chiropractor and staff members the nature and purpose of chiropractic treatment in general and my treatment in particular (including chiropractic adjustments) as well as the contents of this consent form. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including chiropractic adjustments and physical therapy modalities. I intend this consent to apply to all my present and future care.

Patient Signature _____ Date _____
Signature of Parent/Guardian _____ Date _____
Staff Signature _____ Date _____

Insurance Information

Primary Insurance Information

Insurance Co. _____
Policy ID# _____
Group # _____
Subscribers Name _____
Subscribers Birthdate _____
Subscribers SS# _____
Subscribers Employer _____
Subscriber Address _____

Secondary Insurance Information

Insurance Co. _____
Policy ID# _____
Group# _____
Subscribers Name _____
Subscribers Birthdate _____
Subscribers SS# _____
Subscribers Employer _____
Subscriber Address _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign benefits directly to Dr. Joe Nalbone, DC 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. Should collections become necessary, the responsible party agrees to pay an additional 30% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Patient Signature _____ Date _____
Signature of Parent/Guardian _____ Date _____
Staff Signature _____ Date _____