CONFIDENTIAL CASE HISTORY

Name ____ Social Security _____-____-_________
Phone ________________________ Text: Y N Email Address ______________________________
Address ____________________________ City ____________________ State _____ Zip ________
Age _____ Birth Date _____________ Marital Status: M S W D How Many Children ____________
Occupation ___________________________ Employer _________________________________
Address ____________________________ City _________________ Office Phone ____________
Name of Spouse ____________________________ Occupation _____________________________
Employer _____________________ Address _________________________ Phone ____________
Name of Nearest Relative ____________________________________ Phone ________________
Referred By ____
Is the condition due to injury or sickness arising out of employment? ________________________
Is the condition due to injury or sickness arising out of auto or other accident? ________________
Number of days lost from work?____ Date symptoms appeared or accident happened?____________
Have you ever had the same or a similar condition? Y N If yes, when and describe: _____________
____
____
Date of last physical examination? _______________
What operations have you had? _______________________________ When? _________________
Serious Illness? ____ When? _________________

Have you had or do you have any of the following symptoms? Indicate **N** for now or **P** for previously had.

Arthritis	N . . . P	Feet Cold	N . . . P	Neck Pain	N . . . P
Asthma	N . . . P	Hands Cold	N . . . P	Nervousness	N . . . P
Backaches	N . . . P	Headaches	N . . . P	Neuritis	N . . . P
Circulation Problems	N . . . P	Heart Trouble	N . . . P	Numbness	N . . . P
Diabetes	N . . . P	High Blood Pressure	N . . . P	Osteoporosis	N . . . P
Difficulty Urinating	N . . . P	HIV Positive	N . . . P	Rheumatic Fever	N . . . P
Digestive Disorders	N . . . P	Loss of Balance	N . . . P	Sinus Trouble	N . . . P
Dizziness	N . . . P	Loss of Smell	N . . . P	Stiff Neck	N . . . P
Extremity Weakness	N . . . P	Loss of Taste	N . . . P	Stroke	N . . . P

What problem brought you to us today? ____
Other doctor(s) seen for this condition? ____
Have you been treated for any health condition by a physician in the last year? Y N
Describe: ____
What medications or drugs are you taking? ____
Family Medical Physician ______________________________ May we contact? Y N

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of case as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: Y N COMPANY ____
Patient's Signature ____ Date _____________
Guardian's Signature Authorizing Care _____________________________ Date _____________

CLINICAL CASE HISTORY

1. What is your major symptom? ____
2. What does this prevent you from doing or enjoying? _______________________________
3. If this is a recurrence, when was the first time you noticed this problem?___________________
   How did it originally occur?____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? ____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _________ Few Hours ___________ Minutes _______________
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____ If yes, describe: ____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe ___________
   ____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _______
   Burning _____ Stabbing _____ Other ____
7. Is there anything you can do to relieve the problem? Yes ___ No ___ If yes, describe ________
   ____
   If no, what have you tried to do that has not helped? _________________________________
   ____
8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____
   Lifting _____ Twisting _____ Other ____
9. List any major accidents you have had other than those that might be mentioned above: ______
   ____
10. Have you ever had any broken bones? ____
    ____
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
12. Remarks: ____
    ____
    Chiro Hx: _________________________________ X-ray Hx: ____________________________

NO SYMPTOMS | EXTREME SYMPTOMS

|____|

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature ____ Date ____________________

Assignment of Benefits
for Direct Payment to Doctor

I, ________________________, hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current policy to KA Smith Chiropractic PLLC as a payment for professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that my insurance policy is a contract between myself and the insurance company, and that I am ultimately financially responsible for all services rendered by KA Smith Chiropractic PLLC.

If my care is attached to a Personal Injury or Workers Compensation claim, I understand that I will be responsible for payment of my account if the Personal Injury or Workers Compensation company denies my claim. This denial can take up to 45 days for the insurance company to investigate.

A photocopy of this assignment shall be considered as effective and valid as the original.

I, furthermore, authorize KA Smith Chiropractic PLLC and/or his agents to process all claims to my insurance company on my behalf, and to carry on day to day communication with my insurance company. I also authorize the adjuster or attorney involved in the case.

If you are not the policy holder/subscriber:

Subscriber's Name:________________________________ DOB:_____________

Address:____ SS #_____-____-_________

Home #:_______________ Cell:_______________ Work:____________ ext.______

Sex: M or F Relation to Patient: _______________________________

Patient/Guardian's Signature:__________________________________ Date:___________________

PATIENT CONSENT

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION

By signing this form you are granting consent to KA Smith Chiropractic PLLC to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 570-7354. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used of disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify that the information given by me is applying for payment under Title XVIII and or Title of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid Claim.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

Print Patient's Name ____

Patient's Signature ____

Guardian Name ____

Relationship ____

Witness ____

VERIFICATION OF NON-PREGNANCY (Female Patients Only)

By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period ___________.

KA Smith Chiropractic PLLC
FINANCIAL POLICY

OUR MISSION

Our office is committed to providing you with the finest care at a reasonable cost. You will find that our overall fees will probably cost you less in the long run than traditional medical costs (ER fees, medical evaluations, surgery, x-ray, MRI, etc.). In order to assist you in maximizing your insurance benefits, and help you with cash arrangements, please read the following guidelines and sign the statement at the end of this form. If you have any questions about our financial policy, please speak with our receptionist before you sign this form!

FIRST DAY FEES (ALL PATIENTS)

It normally takes our insurance department 24 hours to verify insurance benefits, or claim status. Therefore, we ask that all first day fees be paid in full by cash, check, or any major credit card. If your insurance company covers your first day fees, you will receive a prompt refund or credit.

CASH PATIENTS

If you have no insurance coverage, have high insurance deductibles, or your insurance policy does not cover chiropractic services, you will be considered a cash patient, and payment will be due at the time of service. Payment can be made by cash, check, or any major card. In order to expedite your check-out time, you may arrange to pay your bill weekly, or authorize an automatic weekly credit card payment. If you are unable to pay in full for all services, and need to arrange an extended payment plan, please let our receptionist know at your second visit.

MEDICARE/MEDICAID PATIENTS

Our office is a provider for Medicare and Medicaid. Under Federal Law, we will file your Medicare/Medicaid claims for you. Medicaid patients are covered 100% for chiropractic manipulations, with no deductible to meet. However Medicaid will only pay for 12 visits a year. In accordance with the Medicare Act, Section 1842(i), this is to advice you that Medicare will only pay for services that they determine to be “reasonable and necessary” under Section 1862(a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not “reasonable and necessary”, under the Medicare Program standard, Medicare will deny payment for that service. Medicare limits reimbursement to manual manipulation. Reimbursement is based on what Medicare thinks is medically necessary. **Maintenance care is not covered. Medicare DOES NOT reimburse for examination, x-rays, therapy supplements or supports from a chiropractor. Medicare patients will be responsible for deductible amounts, non-covered charges and any denied visits, which exceed Medicare guidelines.**

I have read and understand the above.

I understand that Medicare may determine that the service performed today may not be “Reasonable and necessary”, and agree to be financially responsible for these services.

____
Patient Initials

GROUP/INDIVIDUAL HEALTH INSURANCE POLICYHOLDERS

If possible, our office will call your insurance company to verify benefits. As a courtesy to our patients, we will file the claims on your behalf at no additional cost to you. If our office can successfully verify benefits, and a proper PCP referral has been made (if applicable), we will accept payment for the portion not covered by the insurance company (deductibles, co-pay, non-covered services) and wait up to 60 days for insurance payment on the balance of your account. If the insurance company does not pay the claim within 60 days, or denies benefits, payment will be due immediately from the patient. Please note that your policy is a contract between yourself and the insurance company. Insurance companies will give us information of coverage, but they never guarantee benefits. As a result, we cannot guarantee benefits, nor be responsible for non-covered services, non-referred services, deductibles, or misinformation given by the insurance company. Additional, patients under HMO/PPO policies requiring Primary Care Physician (PCP) referral will be responsible for obtaining their referrals and referral renewals.

ON THE JOB INJURY/WORKER'S COMPENSATION

An approved Worker's Compensation claim normally pays 100% of chiropractic services. Upon being released from care, a three month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you terminate care without the doctor's approval, payment for services will be due immediately.

PERSONAL INJURY/AUTOMOBILE ACCIDENTS

If you have been injured in an automobile accident, or other type of accident (fall at a store, your home, someone else's home, etc.), you may be covered 100% for chiropractic care. Please obtain a supplemental information sheet from the receptionist, and sign the deferred payment section on that form.

PATIENT/RESPONSIBLE PARTY STATEMENT OF UNDERSTANDING

I have read and understand the Financial Policy of KA Smith Chiropractic PLLC as it pertains to my financial situation. If I have no insurance coverage for chiropractic services, I understand that I am responsible for payment as services are rendered, or by mutual arrangement. I understand that my insurance policy is a contract between myself and my insurance company, and that I am ultimately responsible for payment of services not covered by my insurance company, regardless of stated benefits and coverage. I understand that if I suspend or terminate my schedule of care without the doctor's release, any outstanding fees will be considered due and payable immediately. I understand that if the insurance company pays me directly for services rendered at KA Smith Chiropractic PLLC, and there is still a balance owing on my account, I will immediately send payment of the balance owed to KA Smith Chiropractic PLLC.

______________________________________ _____________________

Patient or Guardian's Signature Date