Community Chiropractic Center INITIAL HEALTH STATUS

Date _____

Welcome to Community Chiropractic Center. Thank you for taking a few moments to tell us about yourself. Please fill out this form as accurately as possible. If you have any questions we will be happy to assist you.

PATIENT INFORMATION

Patient Name: _____ Gender: M F

Date of Birth: _____/_____/_____ Age_____ Weight _____ Height _____

Marital Status: M S D W Emergency Contact Name/Phone #_____

Spouse's Name: _____ How many children: _____

Patient Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Referred by: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone Number: _____

Primary Care Physician Name: _____ PCP Phone: _____

Zip code or town of PCP's office: _____ Do you give permission to send your PCP a report? Yes No

INSURANCE – Please provide your card to our staff

Policy Holder's Name: _____ Relationship to patient: □ Self □ Spouse □ Child □ Other

Insurance Company: _____ ID # _____

Policy Holder's Date of Birth: _____/_____/_____ Secondary Insurance? Yes No (please present card)

HISTORY OF COMPLAINT (what condition(s) are you consulting us for today).

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Other: _____

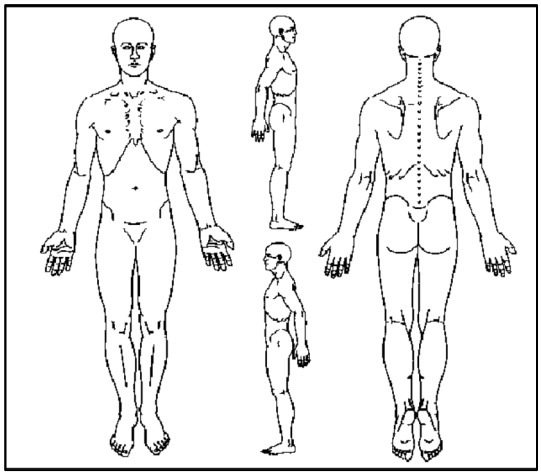
_____

Is this? □ Work Related □ Auto Related □ N/A

Date Problem Began: _____

How Problem Began: _____

_____



Mark an X on the picture where you have pain or other symptoms

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable Pain

How often are your symptoms present?

(Occasional) □ 0 - 25% □ 26 – 50% □ 51 - 75% □ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, household chores)?

0 1 2 3 4 5 6 7 8 9 10
No interference Unable to carry on any activities

In general would you say your overall health right now is:

□ Excellent □ Very Good □Good □ Fair □ Poor

Have you had spinal x-rays, MRI, CT Scan for your areas of complaint? Yes No Date: _____

Area(s) taken: _____

What aggravates your health problem? (circle all that apply) Coughing Sneezing Walking Reaching Lifting Bending Sitting Lying down Standing Neck movement Bowel movement Other _____

What relieves your health problem? (circle all that apply) Nothing Resting Heat Sitting Standing Ice Other _____

Have you had recent treatment for this condition? Yes No **Who did you see?** _____

Treatment received: _____

Have you had chiropractic care before? Yes No **Preference of technique:** hands instrument No preference

SOCIAL HISTORY

Smoker _____ Yes or_____ No, If Yes, How many packs _____ How many years_____

Other forms of Tobacco _____Yes or_____ No, If Yes, How much _____

Alcohol _____ Yes or_____ No, If Yes, How much _____

Exercise _____ Heavy _____ Moderate _____ Light _____ None

Sleep _____ Heavy _____ Moderate _____ Light _____ None

Appetite _____ Heavy _____ Moderate _____ Light _____ None

HEALTH HISTORY

Please check all of the following that apply to you:

□ Alcohol/Drug Dependence
□ Recent Fever
□ Diabetes
□ High Blood Pressure
□ Stroke (date) _____
□ Corticosteroid use (Cortisone, Prednisone, etc.)
□ Taking Birth Control Pills
□ Dizziness/Fainting
□ Numbness in Groin/Buttocks
□ Cancer/Tumor (explain) _____
_____
□ Osteoporosis
□ Other Health Problems (explain) _____
_____

□ Prostate Problems
□ Menstrual Problems
□ Urinary Problems
□ Currently Pregnant, # Weeks _____
□ Abnormal Weight □ Gain □Loss
□ Marked Morning Pain/Stiffness
□ Pain Unrelieved by Position or Rest
□ Pain at Night
□ Visual Disturbances
□ Surgeries _____
_____
□ Epilepsy/Seizures

(Female) Date of last menstrual period _____

(Female) Do you have any reason to believe that you may be pregnant? Yes_____ No_____

Are you currently taking any medications? (Please circle one) **Yes** **No** If yes, please list with date started:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? (Please circle one) **Yes** **No** If yes, please list:

_____

_____

Family History: □ Cancer □ Diabetes □ High Blood Pressure □ Heart Problems/Stroke

□ Rheumatoid Arthritis □ Other _____

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health benefit through the provider, I understand that I am liable for all services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that payment of services is due at the time of service unless other financial arrangements have been made. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE _____ DATE _____

Informed Consent

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The doctor is aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should inform the doctor when he/she takes you clinical history.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE _____ DATE _____

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to
HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she been informed of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE _____ DATE _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

FINANCIAL POLICY & AGREEMENT

SOURCE OF PAYMENT
The Financial Policy of Community Chiropractic Center. (the "Company") requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made. The Company generally accepts payment from the sources identified below. If you have any questions related to your available sources of payment, please ask any staff member of the Company.

PRIVATE PAY (NO INSURANCE) – If you do not have insurance or another party who may be responsible for paying for your health expenses, you are responsible for payment and must bring your account current at each visit. As a service to you, the Company offers no - interest and low - interest financing through CareCredit Patient Payment Plans. Please ask a staff member of the Company for more information related to payment plans, if you are interested.

PERSONAL INJURY or AUTOMOBILE ACCIDENTS – Injuries sustained as a result of an auto-related incident will be submitted under a personal injury claim. Please provide your automobile insurance information, claim number, insurance adjuster's contact information and health insurance information so that the Company can promptly process your claims. If an attorney is handling your case, please notify the Company as soon as possible. Although you are ultimately responsible for payment, the Company will wait for payment until your claim is settled, so long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

"**ON THE JOB" INJURY (Workers' Compensation)** – If you are injured on the job, your care may be paid for under your employer's Workers' Compensation insurance policy. You will need to inform your employer of the accident. Please provide the contact information for your employer's Workers' Compensation insurance carrier, your claim number, and your health insurance information so that the Company can promptly process your claims. If an attorney is handling your case, please notify the Company as soon as possible. Although you are ultimately responsible for payment, the Company will wait for payment until your claim is settled, so long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

MANAGED CARE PLANS – The Company are preferred providers for the following HMO's and PPO's: Aetna, Keystone Health Plan East, Keystone 65. Please note your insurance may be a subsidiary of the previously listed insurance companies. Please contact your HMO or PPO directly to discuss the benefits available to you, your responsibility for paying cost-sharing amounts, and any referral requirements.

FLEX PLANS/MEDICAL SAVINGS ACCOUNT PLANS –Upon request, the Company will provide you with a statement of your charges for your use in seeking reimbursement under a Flex Plan or Medical Savings Account Plan.

INSURANCE –The Company accepts assignment of insurance benefits in lieu of cash payments for certain services rendered to you. The Company is willing to investigate the availability of insurance benefits, upon request. If so requested, you must provide accurate and up-to-date insurance information. Please be prepared to present your insurance identification card at each visit. The Company's communication with your insurance company is not a guarantee of payment. The Company encourages you to contact your insurance company directly for detailed coverage information. The Company will also assist you if you need help in filing claims with secondary insurance providers. The Company attempts to keep track of individual insurance plans and the amounts that they typically pay for procedures. However, plans routinely change, thus the estimated insurance payment may vary from your insurance company's actual payment. When your insurance payment is received, any necessary adjustments (credits or debits) will be made to your account. It is important to remember that your insurance coverage is a contract between you, your employer (if applicable), and your insurance company. While the Company will seek payment from your insurance provider before looking to you for payment, you are responsible for certain upfront fees. These may include, among other fees, co-payments, deductibles, non-covered services, or and co-insurance amounts, as applicable. You will also be responsible for any amount that is not covered by insurance minus any applicable fee schedule discounts.

MEDICARE–The Company accepts Medicare reimbursement for services rendered to you. However, Medicare

covers only medically necessary manipulation of the spine and will only pay for 80% of the allowable fee once the deductible has been met. You will remain responsible for the remaining portion of the allowable fee, any deductible, and all other services or tests (including X-rays and examinations). The Company will make every reasonable attempt to secure payment for your services from Medicare.

APPOINTMENT SCHEDULING - Please help us serve you better by keeping scheduled appointments. Please give 24-hours notice if you need to change an appointment. We reserve the right to charge a missed appointment fee for repeat offenders who fail to give 24 hours notice. Further, understand that non-compliance with your prescribed treatment plan may negate our ability to represent your services as medically necessary to your insurance carrier. This is to remind you that in order for the services performed in this clinic to be billed to your insurance carrier, those services must be considered to be medically necessary. Part of satisfying the medical necessity requirements is for this clinic to develop a treatment program that is oriented toward improving your level of functionality to your maximum potential. Our ability to assist you with meeting these goals is based on your commitment to your prescribed treatment program. Non-compliance with your treatment plan will interfere with our ability to make the progress that is required by your carrier to establish the medical necessity of the services.

Well Visits/Maintenance/Supportive Care – Community Chiropractic Center strongly encourages well care for patients. It is always easier to maintain your health than to fix a more substantial health problem. Insurance companies such as Medicare, Blue Cross Blue Shield, Independence Blue Cross, Aetna, etc. consider well visits as a non-covered service. "Supportive care has been defined as treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Continuation of chiropractic care is considered medically necessary until maximum therapeutic benefit has been reached, when the patient fails to progress clinically between treatments, or when pre-injury/illness status has been reached. Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is not considered medically necessary and thus is not covered. "Patients are responsible for the cost of their well visits.

PAYMENT POLICY

- Payment is due at the time of service, unless other arrangements have been made.
- For your convenience, the Company accepts cash, checks, CareCredit (payment plan), Visa, MasterCard and Discover.
- An insurance contract is between you, your employer, and your insurance company; therefore, it is your responsibility to keep the account current.
- You will be notified when your insurance reimbursement goes beyond 45 days without payment. At that time, you should contact your insurance company to request payment. After 90 days, you will be billed and expected to make payment in full.
- Patients involved in litigation (law suits) are responsible for payment of their services, as outlined above. In its discretion, the Company may agree to wait for payment until the final disposition of your claims is reached, so long as you are an active patient.
- Any fees for services rendered will be immediately due and payable if you suspend or terminate care.
- Any amount paid to the Company relates to services only; x-rays, medical records, and other physical property will remain the permanent property of the Company.
- 24-hours' notice is required when cancelling or rescheduling appointments. The Company reserves the right to charge up to the full amount owed for scheduled services in the event you do not cancel with a 24-hours' notice (including no-show appointments). Cancellation fees are your responsibility, will not be charged or submitted to insurance, and must be paid in full before your next visit.
- In the event that your check is returned due to insufficient funds, you will be assessed a $25 fee.

ASSIGNMENT AND AUTHORIZATION - I hereby assign to the Company all medical and other benefits, including major medical benefits, related to the services provided to me by the Company. I further authorize and direct my insurance carriers (including Medicare, private insurance and any other health or medical plan) to issue payment directly to the Company for services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to pay the Company any money that I receive from my insurance carrier for services provided to me for which I have not paid the Company. I hereby authorize the Company to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual of r electronic. Furthermore, I authorize the release of my medical records, including protected health information, to secure payment and/or to receive medical information pertaining to my case in the Company's clinic. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as collection agency fees, court costs, and attorney fees.

My signature indicates my understanding and agreement to the policies stated above.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE _____ DATE _____

AUTHORIZATION TO SEND EMAIL/TEXT MESSAGES

By signing this form, I authorize Community Chiropractic Center (CCC) to send emails and text messages to my cell phone to convey information regarding my scheduled appointments and any other pertinent office information such as closings or delays.

I understand that standard text messaging rates will apply to any messages received from CCC. I also understand that I may revoke this permission in writing at any time.

I agree not to hold CCC liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform CCC.

Name:_____

Cell Phone #:_____

Cell Phone Provider:_____

(Example: AT&T, T-Mobile, Sprint, Verizon, etc.)

Email Address:_____

Signature:_____

Date:_____

Privacy Disclaimer: This text message/email program is provided as a service to patients to give important information in a timely manner. Your information will not be sold, distributed, or in any other way shared with entities or affiliates outside of Community Chiropractic Center.