Johnson Chiropractic
& Holistic Health Center
Kody R. Johnson, D.C., MS, MTAA

Hanft Family Chiropractic
Jason M. Hanft, D.C.

## General Information

Full Name (First, MI, Last): _____ DOB: _____ Gender: M F

Mailing Address: _____ Married: □ Yes □ No

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Work Phone: _____

Emergency Contact Name & #: _____

Are you here for: □ Chiropractic □ Acupuncture / Dry Needling □ Functional Medicine

Have you seen a chiropractor before? □ No □ Yes Have you had acupuncture before? □ No □ Yes

If you were referred please put their name: _____

## Assignment of Benefits (ONLY if you have insurance)

Insurance Provider: _____ Member ID: _____

Name of Insured (Name on Card): _____ DOB: _____

OFFICE USE:

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Hanft Family Chiropractic, Inc. and / or Johnson Chiropractic & Holistic Health Center, LLC for services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier, or other medical entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Signature: _____

Relationship to insured: _____ Date: _____

Office: 573 – 447 – 0841
Fax: 573 – 875 – 4673
chirokodydc@gmail.com

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## Present Complaint and Health History

What is your SINGLE major reason for seeing us today?
□ Neck Pain □ Headaches □ Other: _____
□ Back Pain: ○ Upper ○ Mid ○ Low

Date current symptom(s) began: _____
Have you had this condition in the past? □ Yes □ No

How did this begin (falling, lifting, etc.): _____
Was it: □ Sudden □ Gradual □ Work Relate □ Auto Accident: Date of Accident: _____
How is your condition changing? □ Getting BETTER □ Getting WORSE □ No Change

How often are your symptoms present: □ Constantly (76 – 100% of the day) □ Frequently (51 – 75% of the day)
□ Occasionally (26 – 50% of the day) □ Intermittently (0 – 25% of the day)

What is your average pain level since on-set? 0 ---------- 5 ---------- 10
No Pain Unbearable

What aggravates / increases your symptoms: _____

What helps / relieves your symptoms: _____

What have you been unable to do: _____

What other treatment have you received: _____

**List ALL Past Medical History conditions:**

□ Arm □ Asthma □ Back Pain □ Broken Bones □ Cancer
□ Chest Pain □ Diabetes □ Headaches □ Heart Attack
□ High Blood Pressure □ Leg Pain □ Neck Pain □ Osteoporosis
□ Other: _____

**List your Family History**:

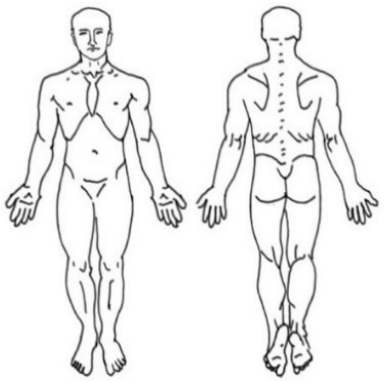
□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression
□ Diabetes □ Epilepsy □ Genetic Spinal Condition □ Heart Problems
□ Heart Attack □ High Blood Pressure □ Multiple Sclerosis
□ Neurological Problems □ Parkinson's □ Polio □ Prostate Problems
□ Stroke □ Other: _____

**List all known medicine, supplement, and environmental allergies or intolerances:** _____

**List or attach a list of ALL prescription or over-the-counter medications and supplements you have taken within the last 6 months:** _____

**List any surgeries: The Year and Body Location:**

Describe the nature of your symptom(s) and mark the location on the diagram below:
□ Aching □ Burning
□ Dull, achy □ Numb
□ Pins & Needles □ Sharp
□ Shooting □ Stabbing
□ Throbbing □ Tightness
□ Other: _____



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## Patient Treatment Agreement Form &
## Clinic Payment Policy – Out of Pocket Payment & Insurance Processing Policy

**Informed Consent:**

- Depending upon your condition, you will require a unique amount and type of care designed specifically for your condition. As with all healthcare types, following the prescribed treatment plan as recommended by the Doctor of Chiropractic does not constitute nor guarantee a cure.
- Chiropractic is a conservative and low risk health care choice. Most common side-effects can include some minor soreness, similar to that which is felt from exercising. A very rare side-effect is vertebrobasilar incident (VBI) or stroke from cervical adjustment. The risk is reported in the scientific literature as being *1:1 million to 1:4 million* adjustments. The likelihood of this occurring is just as common as if you were to get your hair washed at a hair-salon, or if you turn your head to look back as you back out of your driveway. Recent research shows that a visit to a Chiropractor's (D.C.) office is just as safe as a visit to an M.D.'s office in this regard. Furthermore, it has been decided that treatment does not cause VBI, rather, patients report to either an M.D. or D.C. for symptoms of a VBI without knowing they are having this syndrome in the first place since it mimics the symptoms of migraine headache or neck pain. Other possible rare complications from care include fracture, or sprain / strain of the affected body regions.
- Other common methods of treating neuromusculoskeletal problems such as taking Tylenol, Ibuprofen, Aspirin, and Naproxen have a significantly higher risk of an adverse event as compared to Chiropractic Care (*3200:1million vs. 1:1million*). Spinal surgery also possesses a significantly higher risk as compared to Chiropractic as well (*15,600:1 million vs. 1:1 million*).
- By signing this form, you are aware of and are taking responsibility for any risks or benefits, and are stating that you would like to begin care here at Our Clinic.

**Consent to Privacy Practices:**

- Your health information is considered to be protected and confidential. Under federal law (HIPAA), Our Clinic must keep your protected health information (PHI) confidential and can only use it within certain guidelines, which may be subject to your prior approval. Our Clinic will use your PHI in order to formulate an appropriate diagnosis and treatment plan, make any necessary referrals; collect payment from your insurance company, attorney, yourself, or any other necessary collections agency, or individual. Of course, you may limit how we use and to whom we disclose your PHI to. You must put any exceptions in writing and give to our front desk staff. By signing this form, you are agreeing to our privacy practices. You are also giving our office the ability to contact you by any means necessary, including but not limited to: mail, email, telephone, fax, etc. If you would like a copy of Our Clinic's "privacy practices policy", please ask any of our staff and they will provide you with one.

**Scheduling, Attendance & Payment Policy; Insurance and Out-Of-Pocket:**

- Any appointment you make is reserved specifically for you. Arriving more than **five** minutes late to an appointment will result in your appointment being treated as a "walk-in", and you will be seen at the next available time.
- If you will be unable to been seen at your scheduled appointment time, you are required to call and inform Our Clinic at least **four** hours before your scheduled appointment time to cancel or reschedule. Failure to do so will result in a No-Call-No-Show, and we reserve the right to charge you the fee expected at time of service.
- Payment is expected in full at the time of service. Fees are not negotiable. Accounts that are due past 30 days will incur a $10 late fee after each 30 days. After 90 days, the amount will be turned into collections. Accounts in the collections process will accrue 15% interest per annum until collected fully. The patient is also responsible to pay court costs, attorney fees, and any other fee associated with the collections process in addition to the fees of their delinquent account. If your health insurance, car insurance, personal injury settlement, worker's compensation insurance, payment or settlement amount, attorney, or any other paying entity fails to pay Our Clinic completely for services rendered, you are still responsible to pay all of the difference due. We have no control over what your insurance company or other paying entity will or will not pay, and Our Clinic will not be held responsible as such. Your signature indicates your agreement with these policies and clauses.
- Payment is <u>required</u> for your amount owed at time of service.
- Our clinic will gladly submit insurance claims on your behalf for services rendered. However, *in the event your health insurance or other paying entity does not cover our services, you (the patient) will be required to pay, in full, any amount not covered. It is your responsibility to know your own insurance benefits, and our clinic does not assume responsibility in the event we are given incorrect insurance benefit quotes* from an insurance company. The act of our office looking up health insurance benefits is a courtesy to you, our patient, but is not a requirement.

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**PATIENT TREATMENT AGREEMENT FORM &**
**CLINIC PAYMENT POLICY - OUT OF POCKET PAYMENT & INSURANCE PROCESSING POLICY** (CONTINUED)

- IF YOU (THE PATIENT) ARE MEETING YOUR DEDUCTIBLE ON YOUR INSURANCE PLAN, YOU WILL BE ASKED TO PAY THE FULL AMOUNT OF YOUR VISIT AT THE TIME OF SERVICE. IF WE ARE EVER IN DOUBT OF THE DEGREE OF INSURANCE COVERAGE PRESENT, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE FULL AMOUNT DUE ON THE SAME DATE OF SERVICE.
- IF YOUR INSURANCE CLAIM IS DENIED, YOU WILL BE ASKED TO PAY THE OUTSTANDING BALANCE ON YOUR ACCOUNT. IF YOU BELIEVE THE SERVICES SHOULD HAVE BEEN APPROVED AND PAID FOR BY YOUR INSURANCE YOU MAY REQUEST THAT WE RESUBMIT YOUR CLAIM(S). IF CLAIMS ARE RESUBMITTED AND APPROVED BY YOUR INSURANCE YOU WILL BE REIMBURSED OR CREDITED BACK FUNDS, IF AND WHEN THOSE DATE(S) OF SERVICE ARE PAID FOR BY YOUR INSURANCE.
- IN NO INSTANCE SHALL OUR CLINIC EVER BE REQUIRED TO RESUBMIT A PREVIOUSLY DENIED CLAIM IF WE EXPECT THE RESUBMITTED CLAIM WILL ALSO BE DENIED.
- WE ARE IN-NETWORK AND / OR ARE PARTICIPATING PROVIDERS WITH MOST, BUT NOT ALL INSURANCE PLANS. BEING AN IN-NETWORK / PARTICIPATING PROVIDER MEANS THAT WE WILL ACCEPT THE CONTRACTED AMOUNT ON CONTRACTED COVERED SERVICES AS PAYMENT IN FULL IN ADDITION TO ANY REQUIRED COPAYS / COINSURANCE PAYMENTS. HOWEVER, IN THE EVENT A SERVICE IS NOT COVERED OR IS NOT A CONTRACTED SERVICE, YOU (THE PATIENT) ARE OBLIGATED TO PAY OUR CLINIC IN FULL FOR SERVICES RENDERED AT OUR CLINIC'S TYPICAL FEE SCHEDULE. IF INSURANCE IS BILLED AND DOES NOT PAY FOR SERVICES RENDERED, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE AMOUNT OUTSTANDING THAT WAS BILLED TO INSURANCE.
- FOR PATIENTS WITH **MEDICARE** COVERAGE, ONLY EIGHTY PERCENT (80%) OF MEDICALLY NECESSARY CHIROPRACTIC SPINAL ADJUSTMENTS ARE REIMBURSED *AFTER MEETING YOUR MEDICARE DEDUCTIBLE*. ALL OTHER CLINIC SERVICES MUST BE PAID FOR OUT OF POCKET. IF YOU ARE A MEDICARE PATIENT WITH A SECONDARY INSURANCE, THERE IS NO GUARANTEE THE SECONDARY INSURANCE WILL COVER THESE OTHER SERVICES; IF NONPAYMENT BY THE INSURANCE COMPANY(S) SHOULD OCCUR IT IS YOUR (THE PATIENT'S) RESPONSIBILITY FOR THE REMAINING AMOUNT. IF MEDICARE DOES NOT FORWARD A CLAIM TO YOUR SECONDARY, IT IS YOUR (THE PATIENT'S) RESPONSIBILITY TO CONTACT MEDICARE TO ENSURE THAT THE CLAIM IS FORWARDED.

**BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ, UNDERSTAND, AND AGREE WITH ALL THE STATEMENTS, POLICIES, AND PROCEDURES LISTED ABOVE.**

PATIENT NAME PRINTED: _____ DATE: _____

PATIENT SIGNATURE: _____

**IF SIGNING FOR A MINOR**

GUARDIAN NAME & RELATIONSHIP PRINTED: _____

GUARDIAN SIGNATURE: _____ DATE: _____

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