“Achieving Better Health”

Welcome to Juniata Chiropractic LLC. Our mission is to provide a conservative method of quality driven health care to the community. Our commitment is to help patients reach their health goals, giving them the opportunity to live life to the fullest.

PATIENT INFORMATION

Name: (Last, First MI) _______________________________________Preferred Name:___________

Address: ____

City: ______________________________________ State:____________ Zip:_______________

Primary Phone: ________________________ Secondary Phone __________________________

Email:________________________________ Gender: M / F Marital Status: Married / Single

Social Security #: ___________________________ Date of Birth: __________________

Student Status: Full Student / Part Student / Non-Student School:____________________

Military Status: Present Military / Past Military / Non-Military Military Branch: ____________________

Employer: Past or present __________________________ Describe your duties: ___________________

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How did you hear about our office? Newspaper Phonebook Drive By Walk-In Internet Facebook

Referral (Please tell us whom, so we can thank them!) ___________________________________

EMERGENCY CONTACT INFORMATION

Full Name: ______________________________________ Phone: ______________________________

Relationship: Child / Parent / Spouse / Other:___________________________

MEDICAL INFORMATION

Primary Care Physician:________________________________Doctor's Phone: ____________________

Last Seen for:_____________________Treatment given:____

CHIROPRACTIC INFORMATION

Have you ever seen a chiropractor before? Yes / No

If yes, with whom?___________________________ How long ago?______________________________

Reason for visit? ____________________________ Were X-rays taken?___________________________

Anything you did or did not like from previous visits to a chiropractor? ___________________________

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FINANCIAL INFORMATION

Insurance Self-Pay (Cash) Worker's Comp Personal Injury/Auto

Other (please explain): ____

PRIMARY INSURANCE (Provide secretary with insurance card)

Primary Insurance ________________________ Policy Holder's Name _________________________

Policy Holder's DOB ______________ Policy Holder's Relationship to Patient _________________

SECONDARY INSURANCE (Provide secretary with insurance card)

Secondary Insurance ________________________ Policy Holder's Name _________________________

Policy Holder's DOB ______________ Policy Holder's Relationship to Patient _________________

Who is responsible for payment? Self / Other - (Relationship) ____________________________

Other than self:

Name: (Last, First MI) ______________________________________Preferred Name:___________

Address: ____

City: _____________________________________ State:____________ Zip:_______________

Primary Phone: ________________________ Secondary Phone __________________________

ACCIDENT INFORMATION (SKIP this section if you were not involved in an accident)

Is your condition due to an: Auto Injury Work Injury Slip and Fall Other Accident (describe below)

Date of Accident_________________________ Place (City/State)________________________________

Auto/Work Insurance Company_________________________

If Auto/Work Injury, have you reported the accident ? No Yes Claim #____________________

Do you have an Attorney for your Auto or Work Comp. injury? Yes No

Please provide Attorney Name, address and phone number. _____________________________________

It is usual and customary to pay for services as rendered unless otherwise arranged.

CONSENT TO TREAT

Informed Consent for Chiropractic Treatment: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by the physicians of Juniata Chiropractic LLC and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_______________________________________ ______________________

Patient or Guardian Signature Date

I hereby authorize the doctor to administer care as deemed necessary

____ _______________________

Child's Name Relationship to Child

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Legal Guardian Signature

HIPAA Notice

HIPAA Notice: I understand and agree to allow this chiropractic office to use their protected health information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your protected health information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your protected health information, we encourage you to read the HIPAA Compliance Form that is available for you at the front desk before signing this consent. If there is anyone you would like to be able to receive your medical records, please inform our office.

_______________________________________ ______________________

Patient or Guardian Signature Date

FINANCIAL POLICY

Dear Patient:

Thank you for choosing Juniata Chiropractic LLC as your health care provider. The following is a description of our financial policy:

Payment for services is due at the time services are rendered.

We accept cash, checks, Visa, MasterCard, Discover, and American Express.

We reserve the right to collect before services are rendered.

All charges are your responsibility whether the insurance company pays or not.

Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.

Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.

If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.

Unless you are insured by Medicare or an insurance group which our doctors are participating members, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered.

We will be happy to assist you in financing should you so desire.

We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with the front desk if you encounter such problems, so that we may assist you in the management of your account.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

_______________________________________ ______________________

Patient or Guardian Signature Date

MEDICARE PATIENTS

Medicare does not pay for maintenance chiropractic care. However, with an x-ray, examination, and treatment plan (Medicare does not pay for), Medicare will pay for the adjustments only in acute chiropractic care. The co-pay for this care is 20% of the cost of the adjustment. If you have questions on what qualifies as acute chiropractic care, please ask the doctor on staff or the front desk.

_______________________________________ ______________________

Medicare Patient Signature Date