Hartford Spinal Care, P.C.

Upper Cervical Chiropractic

INFORMATION/APPLICATION FOR CARE

______________________________ ___________________ _____ _____/_____/_____

Last Name First Name MI Date

______________________ _____________________________________ _____/_____/_____ ______

Street City/State/Zip DOB Age

__________________ ____________________ M / F _______________________

Home Phone # Cell Phone # Sex (circle) Social Security #

May we leave a message on your phone? **Yes** or **No** Would you like to receive our newsletter by e-mail? **Yes** or **No**

Would you like to receive appointment reminders? **Yes or No** Reminder preference? **Text or Email**

E-mail Address____ Cellular Carrier _______________________

Height______________ Weight______________ Preferred Language________________ Race__________________

Ethnicity________________ Smoking Status: (circle one) Current Every day/Current Some Day/ Former / Never

Current Active Medications____

List Medication Allergies____

What is your major complaint?____

Is your condition related to an accident? No____ Yes____ Type: Auto____ Work/Job____ At home____ Other____

How long has it been since you *really* felt good?____

_______________________________________ ______________________________ ____________________

Employer Street, City, Zip Phone

_______________________________________ _______-_______-_______ _______________________________

Emergency Contact: Name Phone # Relationship

Marital Status: S M W D

_________________________________ _________________________ ________

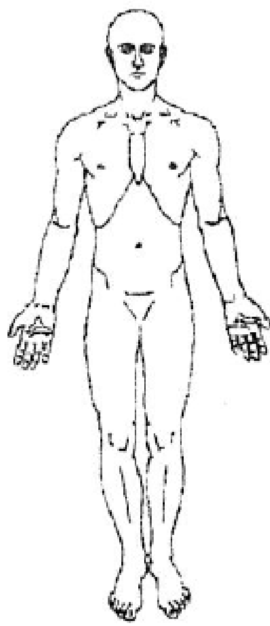
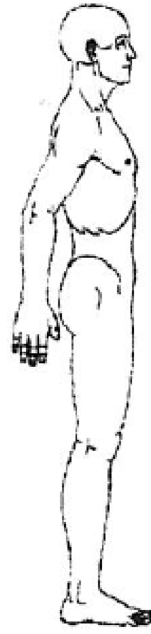
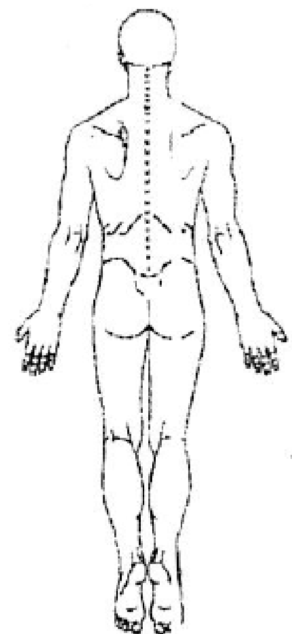
Last Name (Spouse/Parent/Guardian) First Name M.I.

Women : Are you pregnant or do you feel there is a possibility you might be? Yes____ No____

Who may we thank for telling you about us? ____

304 W Hwy 38, Suite 122 / PO Box 446 Hartford, SD 57033 (605)528-6240

Please circle areas of pain and draw lines if the pain radiates.

Chief Complaint (Briefly describe in your own words the chief complaint, the date it started and how or why it started)

____

____

____

Additional Complaint(s) (Briefly describe in your own words)

____

____

____

Please circle the number that best describes the amount of pain you have on scale from

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

O= no pain
1-3 Mild pain; nagging, annoying; interfering little with daily activities
4-6= Moderate pain; interfering significantly daily activities
7-10= Severe pain; disabling unable to perform daily activities

This above information is accurate to the best of my knowledge:

Patient/ Name:____ Date:____________________

Guardian Name: ____ Date:____________________

I authorize and consent the treatment of my child. ____

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OFFICE FINANCIAL POLICY

To our patients:

Thank you for selecting our office to provide Chiropractic care for you and your family members. Before services can be initiated; it is essential that you are aware of the billing and payment policies of our office.

1. **Payment is expected at the time of services**. Our office accepts Discover, Visa and MasterCard.

2. Unfortunately, most health care plans are too restrictive and require providers to agree to contracts that are insufficient to address the needs of most patients. For this reason, our doctor is not a provider of any networks. If out of –network benefits are available call your insurance company to find out.

3. As a courtesy to our patients, we will assist you in filing your insurance claims. Your policy is a legal contract binding between you and your carrier. Thus, we will not act as a mediator, enter into any dispute, **or attempt to know what your coverage is.** We do not accept assignment of payments from insurance companies. **We can not assume any responsibility for their performance.** Again, our office policy is: payment is expected at the time of services.

4. This office may make payment plan arrangements on an individual basis. Therefore, any unpaid balance after the 31st of the month will be subject to a 3% interest charge.

5. Patients involved in a workman's comp or other accident are required to make a 20% co-pay, maximum of $30.00 per visit, at time of service. Patients are ultimately responsible for payment in the event that insurance does not pay.

MEDICARE PATIENTS

Medicare will not pay for X-rays or exams. Spinal Adjustment may be denied as not medically necessary by the program standards.

I have read and understand the policies stated above.

______________________________ ____________________

Patient Signature Date

Hartford Spinal Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ____, (Please Print Name)

have received a copy of this office's Notice of Privacy Practices.

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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