Hartford Spinal Care, P.C.
Upper Cervical Chiropractic

INFORMATION/APPLICATION FOR CARE

_____ _____ _____ _____/_____/_____
Last Name First Name MI Date

_____ _____ _____/_____/_____ _____
Street City/State/Zip Date of Birth Age

_____ _____ M / F _____
Home Phone # Cell Phone # Sex (circle) Social Security #

E-mail Address_____

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

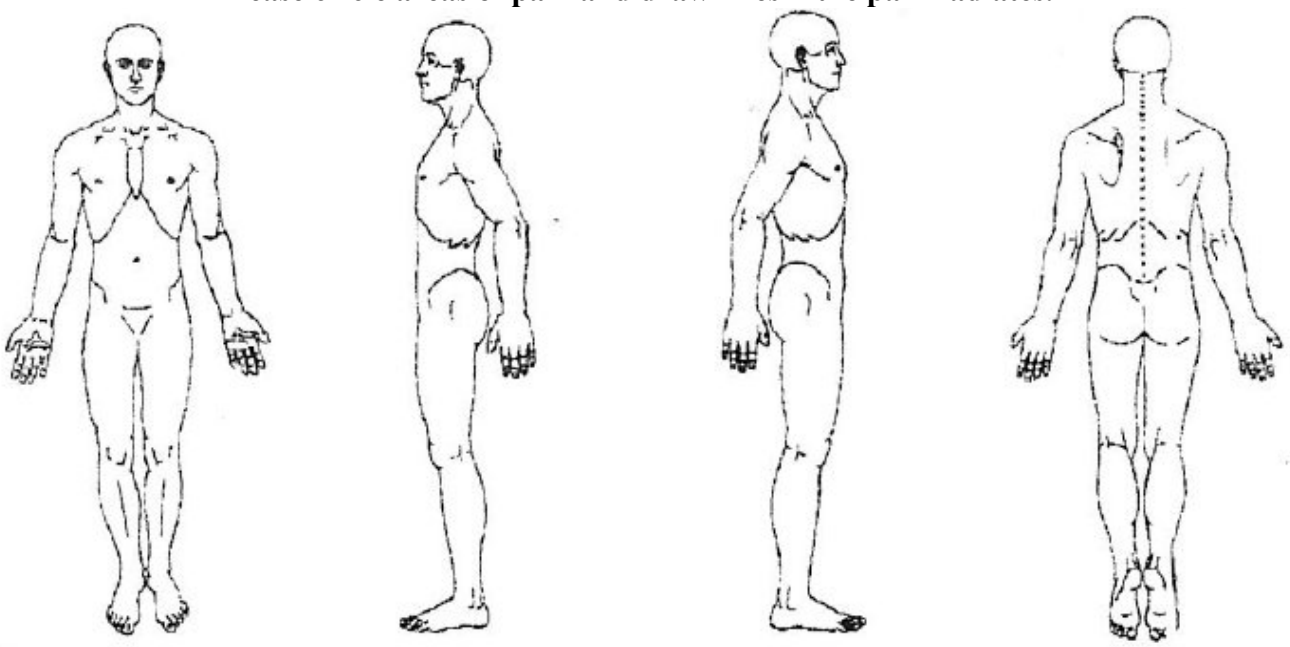
_____ _____ _____
Last Name (Spouse/Parent/Guardian) First Name M.I.

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:_____

Patient Signature: _____

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 cash, check or card. There is an additional processing fee for all card transactions of 3.75%.

2. 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.

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.**

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)

_____

_____

_____