Confidential Patient Information

First Name:	Last Name:	Middle Initial:
DOB: ☐M ☐F	Age:	Gender:
Street Address:	City & Zip:	Home Phone:
Cell Phone: ☐Yes ☐No	Can we send Text Reminders for Upcoming Appointments?	
Email:	May we contact you via Email? ☐Yes ☐No	
Marital Status:	#of Children:	Occupation:
Emergency Contact:	Emergency Relation:	Emergency Phone:
Who is your primary care physician?		
Date and Reason for last doctor visit?		
Are you also receiving care from any other health professionals? ☐Yes ☐No - If yes, please name them and specialty.		
How did you hear about us?		

Financial Information

Please select one which best applies:

☐I will be paying for services myself ☐Health Insurance ☐Auto Insurance ☐ Worker's Compensation

Insurance Company Name:	Policy #:	Group#
Subscriber's Name:	Subscriber's DOB:	Relationship to Subscriber:

Chiropractic History

Have you ever visited a chiropractor? ☐Yes ☐No	If yes, what is their name?	Date of Visit:
What would you like to gain from chiropractic care? ☐Resolve existing condition(s) ☐ Overall Wellness ☐Both		
Do you have any health concerns for other family members today?		

Your Health Goals

What are your top three goals for starting care in our clinic?

1._____

2._____

3._____

Current Health Condition(s)

What health condition brings you into our office?

When did the condition first begin?

Have you received care for this condition before? ☐Yes ☐No
-If Yes, please explain:

How did the problem start? ☐Suddenly ☐ Gradually ☐Post-Injury

Is this condition:
☐Getting Worse ☐Improving ☐Constant ☐Unsure

Throughout the day, is this condition:
☐Constant 100% ☐Frequent 50-75% ☐Intermittent 25-50% ☐Occasional 0-25%

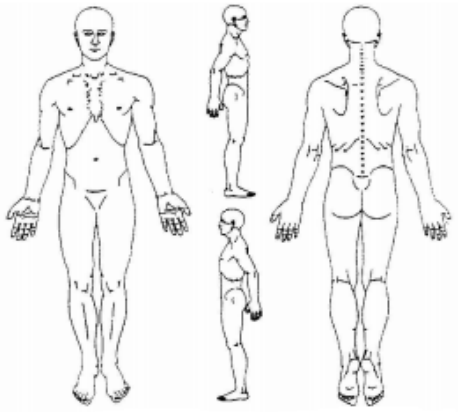
What makes the problem better?

What makes the problem worse?

Intensity of your symptoms: Best 1 2 3 4 5 6 7 8 9 10 Worst

How has the condition interfered with your normal daily activities?

Please indicate where you have pain or other symptoms:



Comments: _____

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ☐Yes ☐No
-If Yes, please explain:

Notable Childhood Injuries? ☐Yes ☐No If Yes, please explain:

Youth or College Sports Injuries? ☐Yes ☐No If Yes, please explain:

Any auto accidents? ☐Yes ☐No If Yes, please explain:

Exercise Frequency? ☐None ☐1-2x per week ☐3-5x per week ☐Daily
-What types of exercise?

How do you normally sleep? ☐Back ☐Stomach ☐Side Do you wake up: ☐Refreshed & Ready ☐Stiff & Tired

How many hours do you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

Alcohol: None ① ② ③ ④ ⑤ High
Water: None ① ② ③ ④ ⑤ High
Sugar: None ① ② ③ ④ ⑤ High
Dairy: None ① ② ③ ④ ⑤ High
Gluten: None ① ② ③ ④ ⑤ High

Processed Foods: None ① ② ③ ④ ⑤ High
Artificial Sweeteners: None ① ② ③ ④ ⑤ High
Chewing Tobacco: None ① ② ③ ④ ⑤ High
Cigarettes: None ① ② ③ ④ ⑤ High
Recreational Drugs: None ① ② ③ ④ ⑤ High

Lease list any drugs/medications/vitamins/herbs/other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

Home:	None ① ② ③ ④ ⑤ High	Money:	None ① ② ③ ④ ⑤ High
Work:	None ① ② ③ ④ ⑤ High	Health:	None ① ② ③ ④ ⑤ High
Life:	None ① ② ③ ④ ⑤ High	Family:	None ① ② ③ ④ ⑤ High

Acknowledgement & Consent

I acknowledge that all of the information that I have given on this form are accurate to the best of my knowledge. I also understand that this information will be held to the strictest confidence and it is my responsibility to inform this office of any *changes in my health or health conditions.*

Patient Name: _____ Date:_____

Financial Policy Summary

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Janning Family Chiropractic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible & choose a pre-payment plan, auto-debit plan or "prompt payment" option.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of 3/1/2017 our office will be unable to extend any type of discounts other than those listed above.

Assignment of Benefits

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance cover chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlements(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien of Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above name doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

Acknowledged by: _____**Date:** _____