# INTEGRATED MUSCLE & SPINE PATIENT REGISTRATION FORM

***All information you supply is confidential. We comply with all federal privacy standards.***

## *Patient Information*

Date: _____ SSN_____

Birthdate: _____ Sex: ☐M ☐F Age: _____

Last Name: _____ First Name: _____ Middle Int.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

□Married □Single □Widowed □Minor □Separated □Divorced □Student □Child

Email: _____

Spouse's Name: _____ Birthdate: _____

* **IN CASE OF EMERGENCY, CONTACT:**

Name: _____ Relationship: _____

Home/Cell Phone: _____ Work Phone: _____

To whom may we THANK for referring you to our office? _____

Have you consulted with a chiropractor before: ☐Yes ☐No If so, Whom: _____

Occupation: _____ Employer: _____ How long: _____

Employer Phone: _____ May we contact you at work: ☐Yes ☐No

Employer Address: _____

**Primary Insurance**: _____ Policy Number: _____

Name of insured: _____ Group Number: _____

Insured's Birthdate: _____ Relationship to Insured: _____

Insured's Employer: _____ Employer Address: _____

**Secondary Insurance**: _____ Policy Number: _____

Name of insured: _____ Group Number: _____

Insured's Birthdate: _____ Relationship to Insured: _____

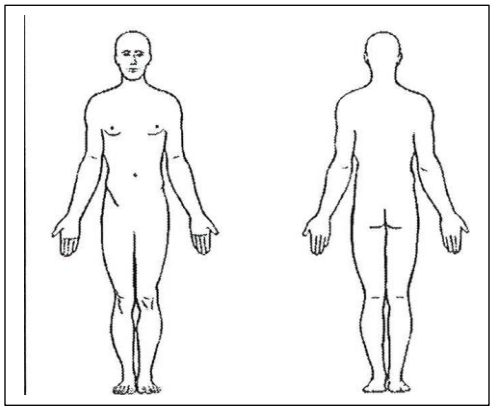
Insured's Employer: _____ Employer Address: _____

# *Patient History*

Reason for your visit: _____ How long? _____

What caused your symptoms? _____

What treatment have you already received for this condition?
□ Medication □ Surgery □ Physical Therapy
□ Chiropractic Srvs. □ Other _____



Other doctor(s) who you have treated you for this condition:
_____

Is this condition getting progressively worse? □Yes □No □Unknown

Mark and X on the picture showing where your pain is located **------->**

Type of pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting
□Burning □Tingling □Cramps □Stiffness □Swelling □Other

How often do you have this pain? _____ Is the pain constant or comes and goes? _____

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation

Activities/movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Are your symptoms the result of an accident? □Yes □No

If YES, what type of accident? □Auto □Home □Work □Other

If work, does your employer know? □Yes □No Who May we contact? _____

## Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the carrier listed and assign directly to Name of Insurance Company.

Integrated Muscle & Spine accepts all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Staff at Integrated Muscle & Spine may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or until I decide to no longer seek care from the doctor(s) actively practicing at Integrated Muscle & Spine.

✓ _____ _____

Signature of Patient, Guardian or Personal Representative Date

_____

Relationship to Patient

# *Health History*

Current Height: _____ Current Weight: _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test _____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Please check all that apply:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aids/HIV | □YES □NO | Diabetes | □YES □NO | Measles | □YES □NO | Psych Care | □YES □NO |
| Anemia | □YES □NO | Emphysema | □YES □NO | Miscarriage | □YES □NO | Rheumatoid Arthritis | □YES □NO |
| Anorexia | □YES □NO | Fractures | □YES □NO | Mononucleosis | □YES □NO | Rheumatic Fever | □YES □NO |
| Appendicitis | □YES □NO | Glaucoma | □YES □NO | Multiple Sclerosis | □YES □NO | Scarlet Fever | □YES □NO |
| Arthritis | □YES □NO | Goiter | □YES □NO | Mumps | □YES □NO | Stroke | □YES □NO |
| Bleeding Disorders | □YES □NO | Gout | □YES □NO | Osteoporosis | □YES □NO | Suicide Attempt | □YES □NO |
| Breast Lump | □YES □NO | Heart Disease | □YES □NO | Pacemaker | □YES □NO | Thyroid Problem | □YES □NO |
| Bulimia | □YES □NO | Hepatitis | □YES □NO | Parkinson's Dis. | □YES □NO | Tonsillitis | □YES □NO |
| Cancer | □YES □NO | Hernia | □YES □NO | Pinched Nerve | □YES □NO | Tuberculosis | □YES □NO |
| Cataracts | □YES □NO | Herniated Disk | □YES □NO | Pneumonia | □YES □NO | Tumors | □YES □NO |
| Chemical Depend. | □YES □NO | High Cholesterol | □YES □NO | Polio | □YES □NO | Typhoid Fever | □YES □NO |
| Chicken Pox | □YES □NO | Herpes | □YES □NO | Prostate Problem | □YES □NO | OTHER _____ | |
| Kidney Disease | □YES □NO | Liver Disease | □YES □NO | Prosthesis | □YES □NO | | |
| Ulcers | □YES □NO | Vaginal Infections | □YES □NO | Venereal Disease | □YES □NO | | |

Any other medical conditions that we should be aware of? _____
_____
_____

Are you pregnant? □YES □NO Due date: _____ OBGYN:_____

| EXERCISE | WORK ACTIVITY | HABITS | |
|---|---|---|---|
| □ None | □ Sitting | □ Smoking | packs/day_____ |
| □ Light | □ Standing | □ Alcohol | drinks/week_____ |
| □ Moderate | □ Light Labor | □ Coffee/Caffeine | cups/day_____ |
| □ Heavy | □ Heavy Labor | □ High Stress Level | reason_____ |

Are there any major injuries/surgeries that we should be aware of? □YES □NO If yes, please explain below:

Head Injuries:_____Date:_____
Falls:_____Date:_____
Broken Bones:_____Date:_____
Dislocations:_____Date:_____
Surgeries:_____Date:_____

Please list any Medications, Allergies, Vitamins, Herbs, Minerals that you may take: _____
_____
_____
_____

# *Financial Policy*

☐ PATIENTS WITHOUT INSURANCE

**We request that 100% of all visits be paid at the time of the service**. If you receive more than one treatment in a week, payment may be made at the end of the week **if you sign a credit guarantee form**. We are happy to accept your cash, check or money order and most major credit cards (American Express is not accepted).

☐ GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not your insurance company and our office. When possible, we will call to verify benefits with your health insurance; however, the benefits quoted to us by your insurance company are not a guarantee of coverage or payment. As a courtesy, we will complete any forms necessary and file to your insurance company. Any services rendered are charged directly to you and you are responsible for any non-covered services, deductible, copays and coinsurance. ***If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your information as up to date as possible.***

☐ "ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

☐ PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Prior to your visit with us immediately notify your insurance company and obtain a claim address, claim number and adjuster/attorney name. There are three options available to you:

1. Pay cash for your care as you are seen. We will gladly submit reports when necessary.
2. We will bill and Accept assignment from the Med Pay portion of your auto insurance. Payment would come directly to us.
3. We will bill your regular health insurance and you will be responsible for all copays, coinsurance, deductible and non-covered services as they are incurred.

Although you are ultimately responsible for your bill, we will wait for a settlement of your claim for up to 6 months after your care is complete. Once the claim is settled or you suspend/terminate care, any feed for services are due immediately.

***If your balance reaches $500 you are expected to set up a reasonable payment plan for payment guarantee.**

☐ MEDICARE/MEDICAID

We do accept assignment from Medicare and Medicaid. The check is usually sent directly to our office in payment of the services that Medicare and Medicaid will cover which for Chiropractors is **ONLY** manual manipulation of the spine.

**Medicare** pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services (Exam and ART Therapy). Our office completes and files the forms for Medicare at no charge. You are responsible for non-covered services at the time of service.

**Medicaid** Patients will have a copay for all members over the age of 18. This is due at the time of service. Medicaid also requires and x-ray be performed every year. We will provide an order to obtain the x-ray; however, it is your responsibility to have x-ray completed.

☐ SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. **Patient is responsible for all fees not covered by their secondary insurance**.

**DELINQUENT ACCOUNTS** **Must Initial _____** ✓

Accounts that continue to be delinquent will be charged a **monthly interest rate of 1.65%.** In the event a delinquent account should go to our collection agency and/or a court settlement the **patient will be responsible for a default fee of all incurred charges.**

**CANCELLATION POLICY** **Must Initial _____** ✓

When cancelling or rescheduling an appointment, a **24 HOUR** notice is required. There are some situations that are beyond our control. We ask that you call as soon as possible when these arise. **IF THIS BECOMES A PROBLEM, YOU WILL RECEIVE "ONE" WARNING LETTER AND THEN YOU WILL BE RESPONSIBLE FOR THE MISSED APPOINTMENT FEE OF $50.00 FOR EACH INCIDENT.**

# ***Acknowledgements***

We are in network with most insurance companies. Please note: Coverage depends on each individual policy. This **does not** guarantee payment or balances owed by you after insurance payment.

I have read and understand the payment policy of Integrated Muscle & Spine. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Integrated Muscle & Spine and my insurance company. I request that Integrated Muscle & Spine Clinic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Integrated Muscle & Spine that fees will be due and payable immediately. I understand and will comply with Integrated Muscle & Spine financial policy.

I reserve the right to ask Integrated Muscle & Spine to not bill my insurance at any time during my care.

✓ _____ _____

**Patient's signature (or guardian if patient is a minor)** **Date**

_____ **(Initials)** I instruct Dr. Kortni, Dr. Tymbree Hawkins and/or Dr. Woodward to deliver the care that, in their professional judgement, can best help me or my child in the restoration of health. I understand that chiropractic care and neuromuscular therapy are a separate and distinct healing art from medicine and does not proclaim to cure any disease or entity.

_____ **(Initials)** I understand that The World Health Organization states "chiropractic care is safe and effective for the prevention and management of a number of health problems when employed skillfully and appropriately". Common, but non-serious side effects include: discomfort, headache and fatigue which will go away in 24-48 hours. Extremely infrequent, but potentially serious side effects include: Stroke, spinal disc herniation, vertebral and rib fractures and caudia equine syndrome.

_____ **(Initials)** Too the best of my ability, the information I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. I have not left out any pertinent information that could have serious side effects to my chiropractic care.

I give Dr. Kortni, Dr. Tymbree Hawkins and/or Dr. Woodward consent to treat **Myself or my minor child**, _____ with Chiropractic Adjustments and/or Neuromuscular Therapy.

✓ _____ _____

**Patient's signature (or guardian if patient is a minor)** **Date**

# *Integrated Muscle & Spine Privacy Acknowledgement*

The department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

**Uses and Disclosures**

- **Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions to all health professionals who may provide treatment or who may be consulted by staff.
- **Payment:** Your health information may be used to seek payment from your health plan or from other sources of coverage such as automobile/workers compensation carriers. For example, your health insurance may request information regarding specific treatments and/or conditions to approve payment of services.
- **Law Enforcement:** Your health information may be disclosed to public health agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- **Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, if we are required to report a communicable disease to the state's public health department.
- **Worker's Compensation:** Your health information may be released to your employer to evaluate work related injuries. Statutes vary from state to state and we will comply with all Iowa and Illinois statutes.
- **Other:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of your authorization. However, the revocation will not affect or undo any disclosure that occurred prior to your notification of revocation.

**Individual Rights**

You have rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information (PHI).
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your PHI.
- The right to amend or submit corrections to your PHI.
- The right to receive how and to whom your PHI has been disclosed.
- The right to receive a printed copy of this notice (please ask the front desk for a copy).
- The right to file a formal complaint to: Centralized Case Management Operations - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F HHH Bldg. - Washington, D.C. 20201

We are required to maintain the privacy of your protected health information and provide you with this notice of privacy practices. We are also required to abide by the privacy policies outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in federal and/or state laws and regulations. The revised policies will be applied to all protected health information.

It is our policy to properly determine appropriate use of PHI in accordance with government rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI.

Thank you for being one of our highly valued patients.

Patient Name: _____ Date: _____

Patient Signature: _____ *Parent or Guardian if child is a minor