

# Welcome

Total Health Chiropractic

Dr. Clifton C. Andrews

285 East 4<sup>th</sup> North

Mountain Home Idaho, 83647

(208) 587-3345 Fax (208) 587-7473

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

*Last Name*

*First Name*

*Initial*

Address \_\_\_\_\_

*City*

*State*

*Zip Code*

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business \_\_\_\_\_

*Address*

*Phone*

*Email*

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_

*Name*

*Phone*

*Cell Phone*

## Reason for Visit

Have you seen a chiropractor?  Yes  No If yes, When and Why? \_\_\_\_\_

Reason for *this* visit: \_\_\_\_\_

Please describe your pain and its location: \_\_\_\_\_

When did symptoms begin (date): \_\_\_\_\_ Have you had similar conditions in the past? \_\_\_\_\_

Is the pain getting:  Worse  Better  Same  Comes and goes

How often do you have this pain? \_\_\_\_\_

Have you been treated by a medical physician for this condition? \_\_\_\_\_ If so, when and where? \_\_\_\_\_

Activities or movements that are difficult/painful to perform:  Sitting  Walking  Bending  Lying down  Lifting

Is pain interfering with:  Work  Sleep  Daily routine  Recreation

Type of pain:  Sharp  Dull  Throbbing  Aching  Burning

Tingling  Numbness  Cramping  Stiffness  Swelling

Other \_\_\_\_\_

Check the following techniques or services:

Used in Past

Interested In Using

Acupuncture / Acupressure

Aqua Massage

Nutritional Supplements / Herbs

Ion Therapy

Nutrition Exam

## Health

List any serious injuries you have had in the last 10 years:

Description

Date

Auto Accident \_\_\_\_\_

Broken Bones \_\_\_\_\_

Dislocations \_\_\_\_\_

Falls \_\_\_\_\_

Head Injuries \_\_\_\_\_  
 Surgeries \_\_\_\_\_  
 Other \_\_\_\_\_

Women: Are you pregnant?  Y  N If so, how far along? \_\_\_\_\_ Nursing?  Y  N

## *Medical History*

List any medication (including supplements and pain killers) you are taking: \_\_\_\_\_

Check yes or no whether you have had or currently have any of the following medical conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke        | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain                  | <input type="checkbox"/> Y <input type="checkbox"/> N Gout                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect    | <input type="checkbox"/> Y <input type="checkbox"/> N Wrist Pain                | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse         | <input type="checkbox"/> Y <input type="checkbox"/> N Shoulder Pain             | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Seizures/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Arm Pain                  | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                   | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain                  | <input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive/AIDS           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems       | <input type="checkbox"/> Y <input type="checkbox"/> N Lower Back Pain           | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Spasms, Where? _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing       | <input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Earaches  | <input type="checkbox"/> Y <input type="checkbox"/> N Numbness, Where? _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                  | <input type="checkbox"/> Y <input type="checkbox"/> N Ringing in the ears       | <input type="checkbox"/> Y <input type="checkbox"/> N Tingling, Where? _____      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                     | <input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                  | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes/Tuberculosis     |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Neck Pain         | <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness                 |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema/Glaucoma         | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis             |   |

## *Personal*

	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

## *Authorization*

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

Chiropractic examination and therapeutic procedures, such as the following: manual spinal adjustment, mechanical spinal adjustment, percussor, cold laser, frequency modulation, infrared light therapy, sound therapy, ultrasound, heat application, ice application, electrotherapy, bio-electric field enhancement, electro-magnetic imaging, allergy-sensitivity testing, crania-sacral therapy, visceral manipulation, electrical stimulation, acupuncture, and applied or clinical kinesiology are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform you about them. These complications include, but are not limited to soreness, inflammation, soft tissue pain, dizziness, and occasionally worsening of symptoms. More serious complications are extremely rare. I give permission for any of the above mentioned procedures. I have read and understand the above statements regarding treatment. I also understand there is no guarantee or warranty for a specific cure or result.

I further understand and acknowledge that no claims of any kind are being made by Total Health Chiropractic as to the effectiveness of any of the nutritional supplements.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

“My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider’s Notice of Privacy Practice.”

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**

# *Total Health Chiropractic*

Dr. Clifton C. Andrews

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Mountain Home, ID 83647

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## *Clinic Financial Policy*

**PLAN #1: NON-INSURANCE:** Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. We accept cash, checks, Visa, MasterCard, Discover, and American Express.

**PLAN #2: MILITARY/TRICARE:** Please ask at the front desk about military benefits.

**PLAN #3: INSURANCE:** If you have insurance, which you know covers chiropractic services, we will bill your insurance company directly. If your deductible has not been met, then payment is expected in full. If your deductible has been met, your co-pay is expected in full. The portion which you are responsible for is due and payable at the time of service. Please provide our front desk person with your insurance card so that we may have a copy of it in your file.

**PLAN #4: MEDICARE:** We do not participate with Medicare, so fees are to be paid at the time that services are rendered and reimbursement for what Medicare allows will be paid directly to you. A finance charge will be computed at the rate of 1.5% per month (18% annually) for unpaid balances greater than 30 days old. We will bill Medicare for you, but what Medicare does not allow is the patient's responsibility. Medicare allows payment on spinal manipulation only and does not pay on any other services. If you have a secondary insurance that needs billing, this is your responsibility (although Medicare does forward these on to your secondary, on occasion). We will be happy to provide you with any assistance or information you require should Medicare not forward your claim to your secondary insurance.

**PLAN #5: WORKERS COMPENSATION:** Under Idaho law, chiropractic services are covered by workers compensation for on-the-job related injuries. We will bill the insurance company directly, providing that you have all of your paperwork, information and referral in order and available to us on your first visit. If, for any reason, the claim is denied you are fully responsible for your fees. A finance charge will be computed at the rate of 1.5% per month (18% annually) for unpaid balances greater than 30 days old.

**PLAN #6: AUTO ACCIDENT:** It is our policy to bill your auto or personal injury policy, if you have all your paperwork, information and insurance company name on you first visit. We will bill your insurance company directly regardless of who is at fault for the accident. IF there is a third party involved, when the claim is settled, their insurance company will reimburse your insurance for all services rendered. If we have not received payment within 90 days, your account then becomes cash and you will be expected to pay for fees at the time services are rendered. When you settle your claim, the entire unpaid balance will be due immediately. A finance charge will be computed at the rate of 1.5% per month (18% annually) for unpaid balances greater than 30 days old.

I have read and understand the policies of the clinic for fee payment. I also understand that health and accident insurance policies are an arrangement between the insurance carrier and myself, the client, not Total Health Chiropractic.

The plan that I have chosen for payment is: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_