inertia HEALTHCENTER

Patient Demographics

Name _____ Date____/____/____

How do you prefer to be verbally addressed? _____

Address _____

City _____ State _____ Zip_____

Phone: Home _____ Work _____ Cell _____

Email _____

SSN _____

Date of birth ____/____/____ Age_____

Marital Status: M S W D Other Spouse's Name: _____

Employer_____

Address _____City _____State____ Zip _____

Name of your Health Insurance Company? _____

Name of primary insured_____

Primary insured's date of birth _____/____/_____

Policy/ID/Member Number _____ Group Number _____

Any changes in your insurance since your last visit? ( ) Yes ( ) No

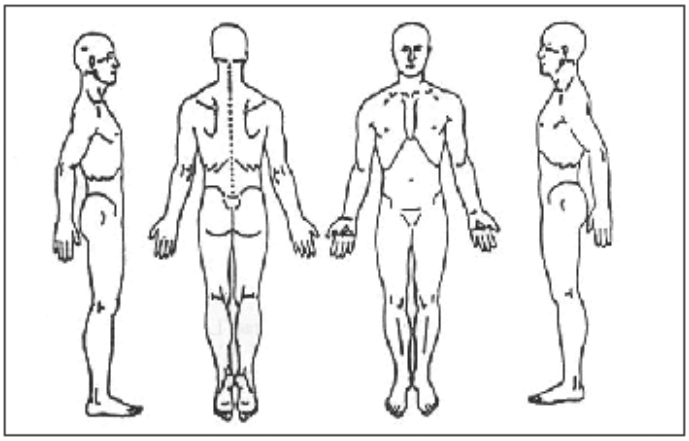
Emergency Contact:

Name_____ Phone Number _____

Relationship _____

Primary Complaint

PLEASE MARK YOUR AREA OF PAIN



What are your present symptoms? _____

When did your symptoms begin? _____

How did your symptoms begin? (i.e. lifting, etc.) _____

Place an "C" on the line below indicating your current pain intensity & "W" indicating worst pain intensity

No Pain _____ Worst Pain

Please describe the character of your current pain. Check all that apply.

( ) Sharp ( ) Stabbing ( ) Burning ( ) Shooting ( ) Aches ( ) Soreness ( ) Weakness ( ) Throbbing ( ) Tingling

( ) Numbness ( ) Dull ( ) Constricting ( ) Other: _____

How often is the primary complaint present?

( ) Constant 100% of the time ( ) Frequently 75% ( ) Intermittent 50% ( ) Occasional 25%

Is it affecting your ability to work or be active? ( ) Yes ( ) No If yes, how? _____

_____

Any change in bowel or bladder (bathroom) function? ( )Yes ( )No _____

Any fever or chills? ( )Yes ( )No _____

Is this effecting your sleep? ( )Yes ( )No If yes how? _____

Do you smoke? ( )Yes ( ) No How much? _____

Do you drink? ( )Yes ( ) No How much? _____

Name and location of family doctor / primary care physician: _____

_____

Is it okay if we keep your family doctor or other doctors informed about your condition? ( ) Yes ( ) No

Terms of Acceptance

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Inertia Health Center SC**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Occasionally chiropractic adjustments, traction, massage therapy, exercise, etc., result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Coaches/Trainers:_____

Others: _____

No one: ____

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

"I authorize the physicians at Inertia Health Center SC to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan."

_____ _____

Print Patient name Date

_____ _____

Patient Signature Parent/Guardian Signature for Minor

Choosing a Payment Option

We are happy to submit the charges for services rendered at Inertia Health Center, SC to your health insurance company, but we also want to make you aware of our self-pay option. We have a self-pay fee schedule that is billable to you the patient at $240 for the initial appointment and then $110 per appointment thereafter. This fee schedule does not fluctuate from visit to visit and your out-of-pocket costs will be fixed. Your out-of-pocket costs for insurance billing will vary depending on your policy details and treatment rendered. Therefore, your lowest out-of-pocket cost may be associated with either option.

Which option would you like to choose? (please circle one)

Self-Pay Insurance

Print Patient name

Date

Patient Signature

Parent/Guardian Signature for Minor

Helping you be healthy, strong, and pain-free

Financial Responsibility

I understand that I bear sole responsibility for payment of services rendered and goods sold to me, or my dependent, at Inertia Health Center (IHC).

_____

Initial

The payment options for services rendered at Inertia Health Center have been fully explained to me. I acknowledge that it is my responsibility to understand the details of my insurance policy. If I receive any information about my insurance policy from the office staff at Inertia Health Center, I understand that the information is unofficial. I accept full responsibility for obtaining information about my insurance policy from my insurance company. I understand that patients choose different payment options for many different reasons. Inertia Health Center is not responsible for understanding the reason I choose a payment option.

_____

Initial

Once my insurance has been billed, I understand that I cannot retroactively change the billing for those services from insurance to self-pay. At any point in time, I am able to switch payment options that affect future billing.

_____

Initial

Late payments and past due accounts may be subject to a 7% interest fee compounded monthly. Any and all costs arising from efforts to collect on past due balances will be added to the total outstanding balance of the bill. The patient will be responsible for paying attorney fees or collection agency fees that are billed to IHC while trying to collect on past due balances.

_____ _____

Print Patient name Date

_____ _____

Patient Signature Parent/Guardian Signature for Minor

Office Policies

Missed Appointments

Inertia Health Center will assess a $45.00 missed appointment fee for each appointment that is not canceled 24 hours prior to the scheduled visit.

Late Payments and Past Due Amounts

Outstanding balances 30 days or older will be due at the time of your next scheduled visit.

Inertia Health Center reserves the right to assess a 7% interest fee compounded monthly on late payments and past due accounts. Any and all costs arising from efforts to collect on past due balances will be added to the total outstanding balance of the bill. The patient will be responsible for paying attorney fees or collection agency fees that are billed to Inertia Health Center while trying to collect on past due balances.

Print Patient name	Date
Patient Signature	Parent/Guardian Signature for Minor