Application for Treatment

Name: _____ Date of Birth _____/ _____/ _____ S.S. # _____-____-_____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____ Is it OK to send you our monthly e-newsletter? Yes No

Name of your Employer: _____

Physical requirements of your job: _____

Check if you are: □ Married □ Single □ Widowed □ Divorced □ Separated

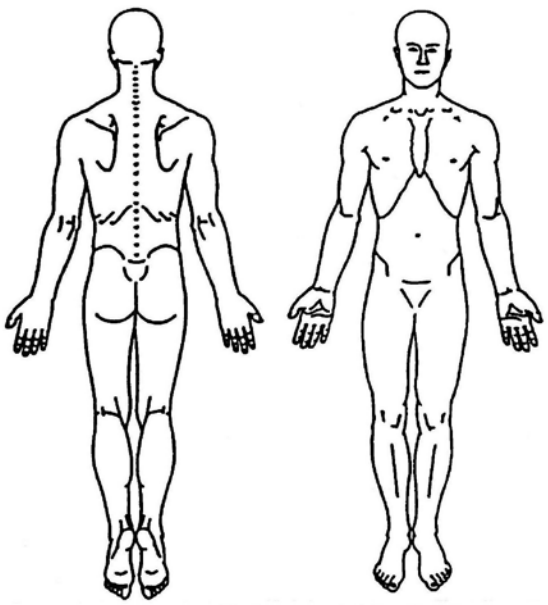
Name of Spouse/Responsible Party: _____ Relationship to Patient: _____

Primary Care Physician: _____ Telephone: _____

Address of Physician: _____

Referred to our office by: _____

Please mark the location/s of your pain or numbness on the diagram below, and number from <u>most</u> bothersome to <u>least.</u>



Briefly describe your major complaint/s:

<u>First time</u> you remember having this problem?

Clark Chiropractic Center • 418 E. Diamond Ave, Gaithersburg, MD 20877
(301) 926-1500 • Fax (301) 926-0462

MEDICAL HISTORY:

Was there a specific activity that started your pain? _____

What seems to make your condition worse? _____

What seems to help? _____

What have you tried so far that has ***not*** worked? _____

When the pain is at its worst, how does it feel? _____

_____

When the pain is at its worst, how much older do you feel than your actual age? _____

Has this problem been getting worse, better, or staying the same? _____

When it is at its worst, how does it affect you at work? _____

_____

When it is at its worst, how does it affect you at home? _____

_____

What do you like to do for fun? (hobbies, exercise, etc.)_____

How has this problem affected your ability to do these things?_____

How has this problem been affecting your sleep? _____

Have you ever been injured in an auto accident (sore afterwards)? □ Yes □ No

If yes, when, and what were your injuries? _____

_____

Please list <u>any</u> other accidents or physical traumas you have had during your life, including childhood: _____

_____

Please list any past surgeries: _____

Do you suffer from: □ Headaches □ Sinus problems □ Digestive Problems □ Painful Menstruation
□ Arthritis □ Loss of smell/taste □ Problem with balance

<u>Any</u> other health problems? _____

Is there a possibility that you are now pregnant? □ Yes □ No

Medications you currently take: _____

Vitamins/Supplement you currently take:_____

Have you been treated previously by a chiropractor? □ Yes □ No

If yes, by whom and what were your results?

_____

Do you have <u>any</u> questions/concerns?_____

<u>I understand that fees are payable at the time treatment is received unless other arrangements are made in advance.</u>

Signature: _____ Today's Date: _____

Assignment of Insurance Benefits

Clark Chiropractic Center
Dr. Steven E. Clark, Chiropractor
418 East Diamond Ave. Gaithersburg MD 20877
(301) 926-1500 * Fax:(301) 926-0462

I authorize permission to my insurance company that all bills submitted by Clark Chiropractic Center be paid directly to them. I understand that health and accident insurance policies are an arrangement between my insurance company and my self – not between my insurance company and this office. I further understand that filing insurance by this office is a courtesy provided to me.

I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms collecting from my insurance company.

Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Relationship to the Insured:_____

Whose name is the policy Under?_____

Policy#_____ Group:_____

Insured's Date of Birth:_____

Social Security Number of Insured:_____

Insurance Company Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Insured's Employer_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature:_____ Date:_____

OFFICE POLICY AND CONSENT TO TREATMENT

APPOINTMENTS

On your first visit the doctor will take a thorough history, and perform a thorough examination, possibly including x-rays. On your second visit the doctor will recommend a treatment plan, laying out the number and frequency of appointments necessary to resolve your problem. You will get the best results, and save time and money, by following this schedule as much as possible. **Please schedule your appointments as far in advance as possible; and should you need to miss an appointment, please do your best to make it up within 7 days.**

PATIENTS WITH INSURANCE

As a courtesy, we will call to verify your insurance coverage, and explain it to you. **Please understand that we are sometimes given incorrect information, and insurance companies have no legal obligation to honor what they tell us.** It is always a good idea to call yourself to double check on your coverage, and to ask for the name of the agent that you speak with. After this is done, and any deductible has been met, we will collect your co-pay at the time of service and wait up to 60 days for your insurance to reimburse the rest.

We file claims monthly. **Should your insurance company deny payment or take over 60 days to pay, you will need to pay any outstanding balance at that time, and resolve the problem with your insurance company. We will provide you with any records you may need to accomplish this, but we cannot fight the insurance company for you.** Your insurance policy is a contract between you and your insurance company. Filing insurance claims is a courtesy provided to you without charge, and in no way relieves you of the responsibility for your bill.

We do not file for secondary insurance, but we will be happy to print out your claims so that you may do so.

ZERO BALANCE POLICY

Our office policy is that all accounts must be current before any further services can be rendered.
After 60 days, any amount due will automatically enter the collection process. Any fees incurred in collecting the overdue amount will be automatically added to the bill.

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor or authorized staff member. I have had the opportunity to discuss with the doctor or staff member the nature and purpose of these procedures, and any concerns I may have. I understand that results are not guaranteed.

I further understand that although chiropractic treatment is extremely safe, no medical or physical treatment is without risk. I do not expect the doctor to be able to anticipate and explain all possible risks, and wish to rely on his judgment as to the safety and appropriateness of any treatment provided to me.

I have read and understand the above, and I consent to all examinations and care as deemed appropriate by the doctor for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the doctor either before or after I sign this contract, and I understand that my consent can be withdrawn at any time.

(Signature)_____ (Date)_____

CLARK CHIROPRACTIC CENTER

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PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI (Protected Health Information) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restriction on the use or release of your PHI than that which is provided by under Federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that is maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE APRIL 15, 2003

This notice is in effect as of 04-15-03.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____