LAKELAND FAMILY
CHIROPRACTIC

Where Health and Well Being Come First!

NAME:_____
FIRST LAST MI

MAILING ADDRESS:_____
STREET ADDRESS

_____
CITY STATE ZIP CODE

PRIMARY PHONE:_____ **SECONDARY PHONE:** _____

GENDER: MALE / FEMALE **BIRTH DATE:** _____/_____/_____

SSN (required if billing insurance): _____

OCCUPATION: _____

E-MAIL ADDRESS:_____

EMERGENCY CONTACT:_____ **PHONE:**_____

ELECTRONIC HEALTH RECORDS INTAKE

In compliance with Medicare requirements for the government EHR incentive program

Preferred method of contact for appointment reminders: EMAIL / PHONE / TEXT

CMS requires providers to report both race and ethnicity and preferred language.

Race (circle one): American Indian or Alaska Native / Asian / African American / Caucasian / Native Hawaiian or Pacific Islander / Other: _____ / Decline to Answer / Unknown

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer / Unknown

Preferred Language: _____

Patient Signature: _____ **Date:** _____

PATIENT NAME: _____

PAST TRAUMAS / SURGERIES

_____APPROXIMATE DATE: _____

_____APPROXIMATE DATE: _____

GENERAL SYMPTOMS OR CONDITIONS

CIRCLE ANY YOU CURRENTLY HAVE OR HAD IN THE PAST

HEADACHES	BLOOD DISORDERS	LOSS OF SLEEP
DIZZINESS	CANCER	BREATHING PROBLEMS
ALLERGIES	VISUAL PROBLEMS	DIGESTIVE PROBLEMS
DIABETES	HEARING PROBLEMS	MENSTRUAL PROBLEMS
HEART CONDITIONS	EAR INFECTIONS	OTHER _____

FAMILY HISTORY

CIRCLE ALL THAT APPLY

CANCER CARDIOVASCULAR PULMONARY GASTROINTESTINAL

Please Explain:_____

CURRENT MEDICATIONS

Please List

Name_____Dosage_____

Name_____Dosage_____

Known Drug Allergies:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:
FEMALE PATIENTS

Are you pregnant or any chance you may be: ____YES____NO

The exam your doctor has ordered uses Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. Such consequences can include stunted growth, deformities, abnormal brain function, or cancer that may develop sometime later in life. You should contact your doctor if you believe you may be pregnant to discuss possible side effects and the risks and benefits of the procedure. If you feel that you may be pregnant, please inform the Radiology Technologist before your exam.

_____ To the best of my knowledge I am not pregnant or believe there is any possibility that I may be pregnant.
_____ I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby.

Signature:_____ **Date:**_____

PATIENT NAME: _____

NOTICE FOR THE POSSIBILITY OF INSURANCE DENIAL

As a courtesy to you, we will bill your insurance directly. Please note if we bill the insurance for your services, you will not be eligible for our 'paid at the time of service' discount, which is 30-50% off our regular customary charges. However, you are always welcome to take advantage of this discount, pay the discounted price at the time of services and then bill your insurance for reimbursement. We will gladly provide you with the 'superbill'.

Your insurance company will only pay for services it determines to be reasonably necessary. If your insurance company determines that a particular service, although it would otherwise be covered, is not reasonably necessary under its program standards, your insurance will deny payment for that service. The following services may not be covered:

- Some or all x-rays
- Re-examinations
- Supplies such as ice packs, pillows, orthotics, and supplements
- Manual traction/mechanical traction
- Massage therapy
- Spinal rehabilitation and exercises
- Office visits deemed 'not medically necessary' by your insurance

RETURN POLICY OVERVIEW

We do not accept returns of any products purchased at Lakeland Family Chiropractic. This will include any pillows, supports, ice packs, and nutritional supplements.

I have been informed by my doctor or staff that in my case, my insurance company may deny payment for some future services. Any quote of benefits received from the insurance company by Lakeland Family Chiropractic is only a quote and benefits will be determined by the insurance company at the time they process any claims. If my insurance company denies payment, I agree to be personally and fully responsible for payment of these services. I understand that I could choose to pay a discounted fee at the time of service.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I understand that Lakeland Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and I authorize Lake Family Chiropractic to release to the insurance carriers, or other payers, any and all information pertaining to my care if needed to process claims. I also authorize my insurance to pay any amount authorized directly to Lakeland Family Chiropractic to be credited to my account.

Note: Your health information will be kept confidential. Any information that we collect about you in our office will be kept confidential. If a claim is submitted to a payer, any health information attained in our office maybe be shared with the payer.

Patient/Guardian Signature:_____Date: _____

PATIENT NAME:_____

AUTHORIZATIONS AND RELEASES

Patient Health Information and Privacy Policy
This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/securitystandard/downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as along as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligation: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial_____

Consent to Professional Treatment
The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of 18 at the date of treatment. I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial_____

Consent to Perform and Interpret X-rays
The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this services and assign benefits to be paid directly to that professional by your third-party payor.

Initial_____

Assignment of Benefits and Release of Records
The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.
The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial_____

Financial Obligation and Appointment Policy
The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointment canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collections agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manage or physical.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment sources supplied by patient to the practice for current and future charges, when incurred.

Initial_____

Signature_____**Date**_____