KRUEGER CHIROPRACTIC

New Patient Information

Basic Information

Patient Name: _____

Nickname: _____ Today's Date: / /

Birthdate: / / Age: Gender: M F SS#: _____

Mailing Address: _____

Preferred Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Email Address: _____

Occupation: _____ Employer's Name: _____

Employer's Address: _____

Insurance

Primary Insured's Name: _____ Primary's Date of Birth: / /

Primary Insured's Employer: _____

Workers Compensation Claim #: _____

Auto Claim #: _____

Statistical Information

Race (choose most appropriate):

☐ American Indian or Alaska Native ☐ African American or Black ☐ Asian

☐ White/Caucasian ☐ Decline to specify ☐ Other _____

Ethnicity (Choose most appropriate):

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to specify

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have any children? ☐ Yes ☐ No ***If yes, how many?*** _____

Who referred you to us? _____ ***and/or*** ☐ Internet

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Medical History

Patient Name: _____

Birthdate: ____ / ____ / ____ Height: _____ Weight: _____

Why are you seeking chiropractic evaluation/treatment today? _____

_____

Have you had similar problems before? ☐ Yes ☐ No If yes, when? _____

Have you had any recent falls, traumas or other accidents? ☐Yes ☐No

Are you off from work? ☐ Yes ☐ No

What is the initial date you began having your symptoms? _____

Is your MD currently co-treating your condition? ☐ Yes ☐ No
If yes, please give Doctor Name/Office: _____

Have you had recent diagnostic studies (X-ray, MRI, CT, blood work) done? ☐Yes ☐No
If yes, where were they taken? _____

List current medications: _____

List your Allergies: ☐ None ☐ Seasonal/Pollen ☐ Food ☐ Animals
☐ Other: _____

List any Surgeries: ☐ None ☐ Neck ☐ Back ☐ Hip ☐ Knee ☐ Shoulder ☐ Brain
☐ Other: _____

List your Medical Conditions: ☐ None ☐ High Blood Pressure ☐ Diabetes ☐ Stroke
☐ Cancer ☐ Other: _____

List your Family Medical History (e.g., maternal grandmother - high blood pressure, father - heart attack):

_____

Do you exercise? ☐ Yes ☐ No What types of exercise: _____
On average, how often do you exercise per week? ☐ 5+ days ☐ 3-4 days ☐ 2 days ☐ < 2 days

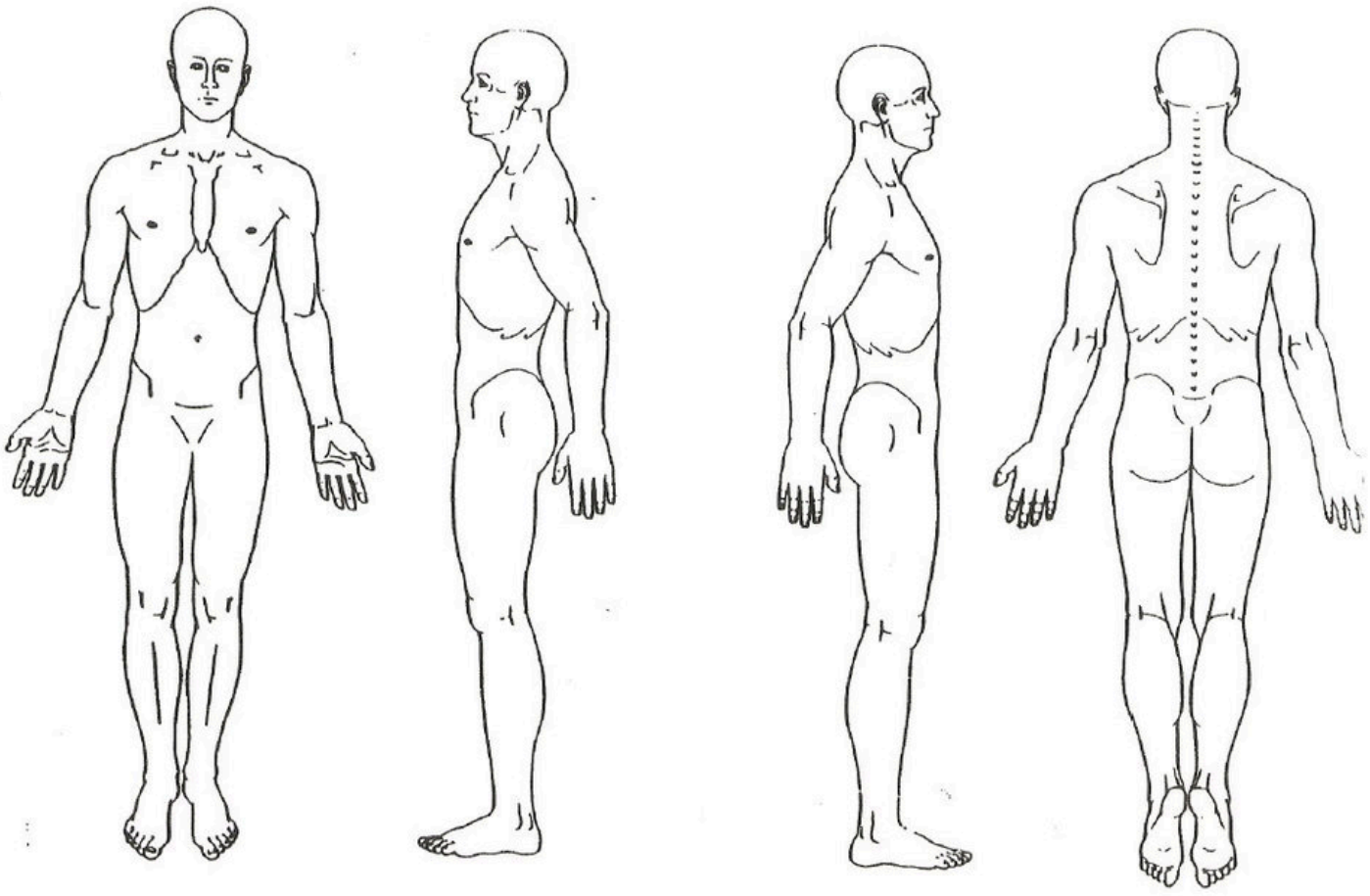
Do you drink alcohol? ☐ Yes ☐ No Drinks per day: _____

Do you drink caffeine? ☐ Yes ☐ No Drinks per day: _____

Do you smoke or use tobacco products? ☐ Yes ☐ No Former smoker? ☐ Yes ☐ No

Do you currently have significant struggles with depression or anxiety? ☐ Yes ☐ No

Please mark an "X" over areas of discomfort.



Duration of pain: ☐ Constant (90-100% of the time) ☐ Frequent (~75% of the time)
☐ Intermittent (~50% of the time) ☐ Occasional (~25% of the time)

On a scale of 1-10, please indicate your current level of pain, with 10 being unbearable pain: _____

What is your pain level when at its worst? Best?

What, if anything, eases the pain?

Do your symptoms prevent or disrupt your sleep at night? ☐ Yes ☐ No

Once you start moving, do your symptoms get: ☐ Better ☐ Worse

When are your symptoms better? ☐ Morning ☐ End of the day ☐ Always the same

At this time, are you are getting: ☐ Better ☐ Worse ☐ Stable

Patient Signature: Date: / /

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Acknowledgement of Receipt of Privacy Practices

Patient's Name: _____ has received a copy of Krueger Chiropractic Clinic's Notice of Privacy Practices.

Patient Signature: Date: / /

Please use the section below if you are signing on behalf of a minor or as a legal guardian.

Parent/Legal Guardian Signature: Date: / /

Parent/Legal Guardian Print:

Patient Authorization for Use and Disclosure of Protected Health Information

I wish to be contacted at the following number: ( ) -

Krueger Chiropractic Clinic has my permission to leave a detailed message concerning appointments or other details of my medical care at the above number. ☐ Yes ☐ No

I grant permission for Krueger Chiropractic Clinic to discuss/release medical & billing information to the following person(s):

Name: Phone: Relationship:

Name: Phone: Relationship:

HIPAA (Health Insurance Portability Accountability Act) privacy rules give you the right to request a restriction of your protected health information (PHI). When PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

Patient Signature: Date: / /

Please use the section below if you are signing on behalf of a minor or as a legal guardian:

Parent/Legal Guardian Signature: Date: / /

Parent/Legal Guardian Print:

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Financial Policy

Chiropractic care is covered under many insurance plans. We ask that you read and understand our policy as it applies to your particular situation.

MANAGED CARE PLANS
Benefits are normally provided after a referral from the primary doctor is obtained. Please reference your specific plan details to discover the proper procedure to follow. If our office "participates" with your managed care plan, we can treat you in accordance with your in-network plan benefits. If we are not "participating," we will be able to verify whether or not your plan offers "out-of-network" benefits.

"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 from the patient immediately.

MEDICARE & Medicare Plans Managed by Insurance
We do participate with Medicare. We will bill Medicare for your adjustment. Keep in mind, Medicare ONLY covers manual manipulation of the spine. No X-rays, exams or therapies are covered. Also, 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. Our office will complete and file the forms for Medicare at no charge.

GROUP OR INDIVIDUAL INSURANCE
When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, MasterCard or Visa.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Complete and return any paperwork they require of you. Notify our insurance department immediately if an attorney is representing you. Pennsylvania is a "no fault" state in regard to auto accidents, therefore your insurance company will be billed for any medical expenses you incur. If you were not at fault for the accident, your insurance company will recoup the sum for bills paid from the company of the individual at fault for the accident. Auto cases are normally covered 100% by insurance coverage. However, if you have a limit on the amount of medical expense coverage you have, you will be responsible for any charges that exceed that limit.

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

Patient Signature: _____ Date: / /

Witness *(for Medicare Patients only)* _____

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Cancellation Policy

If a cancellation must be made for a scheduled appointment or massage, we need to have 24 hours notice. This prevents inconveniencing our office and staff, as our time is valuable. If you are unable to notify us at least 24 hours prior to a cancelled appointment, you will be charged a $20.00 cancellation fee.

Patient Signature: _____ Date: / /