Chiropractic Registration

Patient Information

Date ______________________

SS/HIC/Patient ID # ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

Address ______________________

E-mail ______________________

City ______________________

State __________ Zip __________

Sex ☐ M ☐ F Age __________

Birthdate ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (_____) ______________________

Spouse's Name ______________________

Birthdate ______________________

SS# ______________________

Spouse's Employer ______________________

Whom may we thank for referring you? ______________________

Insurance Information

Who is responsible for this account? ______________________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate __________ SS# __________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to
Name of Insurance Company(ies)

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

__________ __________
Date Relationship to Patient

Phone Numbers

Cell Phone (_____) __________ Home Phone (_____) __________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name __________ Relationship __________

Home Phone (_____) __________ Work Phone (_____) __________

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date __________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________________

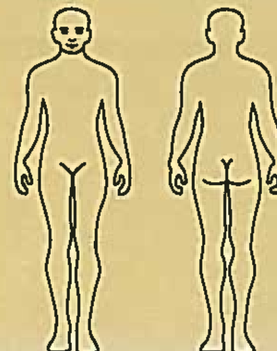
Patient Condition

Reason for Visit ______________________

When did your symptoms appear? ______________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) __________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______________________

Is it constant or does it come and go? ______________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ____________

Name and address of other doctor(s) who have treated you for your condition ____________

Date of Last: Physical Exam ________ Spinal X-Ray ________ Blood Test ________
Spinal Exam ________ Chest X-Ray ________ Urine Test ________
Dental X-Ray ________ MRI, CT-Scan, Bone Scan ________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ________		
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Cataracts	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No			

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/Day ________
☐ Alcohol — Drinks/Week ________
☐ Coffee/Caffeine Drinks — Cups/Day ________
☐ High Stress Level — Reason ________

Are you pregnant? ☐ Yes ☐ No Due Date ________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name		
Pharmacy Phone ( )		

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PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA FORM)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent from stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient understands that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts know to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known, is in my best interest and that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse given care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures and also give consent for chiropractic care.

____

Signature of Patient　　　　　　　　　　　　　　　　　　　　　　　Date

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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name:_______________________________________ DOB: _____/_____/_______

Release of Information:

[ ] **I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.**

This information may be released to:

[ ] Spouse: ____

[ ] Child(ren): ____

[ ] Other: ____

[ ] **Information is not to be released to anyone.**

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number:______________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is:

Day:__________________________________ Between (time):______________________

Signed:____ Date: _____/_____/_______

Witness:____ Date: _____/_____/_______

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FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE: **This includes all applicable office charges, coinsurance, deductible and copayments for participating insurance companies.** After 30 days of non-payment, a **$1.50 late payment charge** will be applied to your account, and an additional charge will be added every 30 days. The office accepts cash, personal checks (there is a service charge of $25.00 for returned checks), VISA, MasterCard and Discover. This office utilizes e-Pay – electronic statements send through email and/or text messages. By consenting to our financial policy, you are giving Life in Motion Chiropractic consent to send balances due via e-Pay.

We bill participating insurance companies as a courtesy to you. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible for all services not covered by your insurance carrier.

We do not bill all secondary insurance companies; primary and secondary must be linked electronically to bill. Please check with your insurance company to verify. Patients will be responsible for charges not billed to your secondary insurance. Your time of service receipt includes all information necessary for you to submit claims to your insurance company.

MANAGED CARE: Some insurance companies require authorizations for chiropractic care. All visits not covered by lack of an authorization or denied by your insurance, for any reason will then become the responsibility of the patient. Please contact your insurance company for details pertaining to your insurances Prior Authorization guidelines. If your insurance denies your authorization for any reason the balance due will be the responsibility of the patient. **An insurance card does not guarantee payment, any changes made to your policy needs to be addressed at your visit.**

MEDICARE, MEDICAID, UPMC for You and UPMC for Life plans do not cover all chiropractic services. Office visit examinations and in office x-rays are not covered.

Auto and Work related charges will be billed to your insurance carrier, if for any reason claims are returned or denied, the balance due will become the patient's responsibility. Life in Motion will not be responsible for any misinformation given on patient's insurance coverage by the insurance companies or patient. **Once Auto/Worker Comp. medical benefit limits have been maxed out the patient will be liable for the balance remaining. Please be aware of your medical payment limits when scheduling your appointments.**

Missed Appointments/Late Cancellations: Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

No Show Policy: If New Patient and/or Second Visit (ROF) is not cancelled and rescheduled prior to the appointment (No Show), a $30.00 charge will be billed to your account.

I have read and understand the **Life in Motion Chiropractic's** Financial Policy. I agree to assign insurance benefits to Life in Motion Chiropractic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured/authorized representative: ______________________________ Date: __________

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INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the Patient: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed.*

I/We hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on ______________________________, by Dr. Nathaniel A. Reese, Dr. Elizabeth E. Smolick-Reese, or any other licensed Doctors of Chiropractic who may be employed by or engaged in practice at Life in Motion Chiropractic Center.

I have had an opportunity to discuss with Dr. Nathaniel Reese, Dr. Elizabeth Smolick-Reese and other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgements based upon the facts known to the doctor at the time, that is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgement, that no one guarantee as to results has been made nor relied upon by me, and I wish to rely on the Doctor of Chiropractic to exercise judgement during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interest.

I have also been advised that there are other rare risks, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below agree to the named procedures.

______________________________ ______________________________
Patient's Name Parent/Guardian Signature

____
Patient's Signature

____
Witness

____
Date

Doctor's Notes

Discussion: ____

Other: ____

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CONSENT TO TREAT OF MINOR CHILD

I/We hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on ______________________________, by Nathaniel A. Reese, DC and/or Elizabeth E. Smolick-Reese, DC, and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my ______________________________(relationship of child).

I/We have had an opportunity to discuss with Dr. Nathaniel Reese and/or Dr. Elizabeth Smolick-Reese and other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicines is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no one guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known, is in my best interest.

I have also been advised that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree to the named procedures.

Dated at Canonsburg, Pennsylvania this __________ day of ______________, 20____.

Signature: ______________________________

Printed Name: ______________________________

Witnessed: ______________________________

Printed Witnessed Name: ______________________________