

NEW PATIENT INTAKE

Today's Date / / Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Would you like appointment reminders sent to you via Text Email Both Neither

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / / Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Continued on back...

Name: _____

Date: ____/____/____

PATIENT REVIEW OF SYSTEMS

Please check the "current" box for all conditions that you are now experiencing and mark the "recent" box for any condition or symptom(s) experienced at any time in your life.

	Current	Recent	Doctor's Notes Only Please do not write in this space.	Current	Recent	Doctor's Notes Only Please do not write in this space.
GENERAL						
Fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sweats	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Chills	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Change in routine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
HEAD						
Headache	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Fainting	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
EYES						
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Double vision	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
EARS						
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Drainage	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
NOSE						
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH						
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
NECK						
Masses	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
LUNGS						
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Coughing up phlegm	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
VASCULAR						
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Cold feet or hands	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Discolored foot/hand	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Hot feet or hands	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
G-I SYSTEM						
Gas	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
G-U SYSTEM						
Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Increased urination	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Genital infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Please turn the page over and complete the checklist on the reverse side.

Doctor's Notes Only
Please do not write in this space.

Doctor's Notes Only
Please do not write in this space.

PSYCHOLOGIC

	Current	Recent
Excessive Stress	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>
SKIN		
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Peeling	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGIC		
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE/BONE		
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
CONDITIONS		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION

	Current	Recent	
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	(please bring a list)
Non-prescribed medication.	<input type="checkbox"/>	<input type="checkbox"/>	(please bring a list)
Vitamins/Herbs/Supplements	<input type="checkbox"/>	<input type="checkbox"/>	(please bring a list)

Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL

Surgery-any area	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL

Consume alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Consume caffeine	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>
Drink ___ glasses water/day		
Sleep _____ hours/night		

OB GYN - For Females

Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Date: ___/___/___

NEW PATIENT INTAKE

- Y N Is this injury work related?
 Y N Is this injury due to a motor vehicle accident?

If yes: What was your date of injury? ____/____/____
 Claim number: _____
 Claim representative/Adjuster's name: _____

Chief Complaint (Briefly describe in your own words your health problem, the date it started and how or why it started)

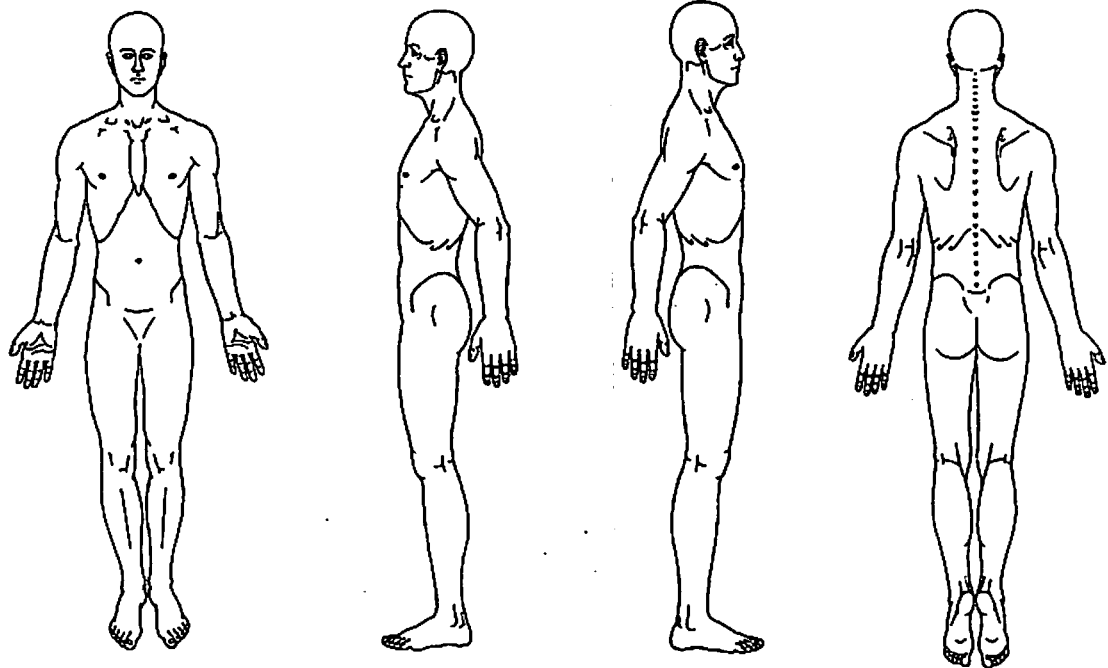
Additional Complaint(s) (Briefly describe in your own words)

Have you been treated by another health care provider for this problem?

Pain Diagram

If your complaint is pain related, please circle areas of pain and draw lines if the pain radiates. Draw on the diagrams below indicating where you have problems using the symbols listed.

- || = Tingling
- < = Numbness
- > = Sensitive
- + = Stiffness
- = Weakness
- ::: = Ache
- ^^ = Burning
- /// = Stabbing
- ooo = Other



Signature: _____ Date: ____/____/____

Name: _____ Date: ____/____/____

BOURNEMOUTH QUESTIONNAIRE

The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Over the past week, on average, how would you rate your pain?

No Pain Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No Interference Unable to Carry Out Activity
0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No Interference Unable to Carry Out Activity
0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at All Anxious Extremely Anxious
0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at All Depressed Extremely Depressed
0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Have Made it No Worse Have Made it Much Worse
0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely Control it No Control Whatsoever
0 1 2 3 4 5 6 7 8 9 10

Patient Health Information Consent Form

CARON
CHIROPRACTIC

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 form 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 Patient Health Information (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 may provide a written request to revoke consent at any time during care. This would not effect 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.
5. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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 to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ **Date:** ____/____/____

Print Name: _____

Authorization and Releases

CARON
CHIROPRACTIC

Print Patient Name: _____

Please initial each section and sign at the bottom of the page.

Consent for Treatment

_____ I, the undersigned, hereby authorize Dr. Martin Caron, Dr. Matthew Caron, and Dr. Timothy Graff/ or whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I also certify that no guarantee of assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Financial Responsibility

_____ I agree to be financially responsible of all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Assignment

_____ I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

Release of Information

_____ I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor and attorney involved in this case; and hereby release this clinic of any consequences there of.

Minor Consent Form

_____ I declare that I am the parent or legal guardian of _____. And I hereby authorize the doctors employed at Caron Chiropractic Clinic and their designated assistants to perform diagnostic tests, examination and treatment as they deem necessary to him/her.

I declare the above information to be accurate and I agree to the above initialed statements.

Signature of Patient or Parent/Guardian of Minor

_____/_____/_____
Date

Financial Policy

CARON

CHIROPRACTIC

CASH: We accept cash, check, Visa, MasterCard, Discover and American Express. Returned checks may be subject to a \$25.00 service charge. We do offer a same day cash discount on services for those not using insurance support. (Not valid on massage or supplies)

GROUP INSURANCE: As a courtesy to you we will bill your primary insurance company for services rendered in our office. It is important that you understand the arrangement of benefits between you and your insurance company. In the event you have secondary insurance coverage we will submit for you as long as it will automatically cross over from your primary insurance. You are ultimately responsible for payment of your bill. We recommend calling member services located on the back of your insurance card with any benefit questions you may have. It is our office policy that all co-payments and coinsurance are collected at the time of service. In the event you are to receive billings, we ask that you pay your bill in the first cycle or a \$10.00 billing charge will be applied for each following month.

WORKERS COMPENSATION: Patients are required to complete a Worker's Compensation Questionnaire. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases.

ACCIDENT AND PERSONAL INJURY: Patients are required to complete a Personal Injury and/or Accident Report form. If you have been involved in a Motor Vehicle Accident, it is important that you report the accident to your motor vehicle insurance agent and request a claim number and appropriate billing information. You will then receive an Application For Benefits in the mail from your automobile insurance company. It is important that this form is filled out promptly and returned to your claims examiner to avoid any delays in your file. If an attorney is involved please let us know.

MEDICARE: The doctors in this office are Medicare providers. We will submit all claims to Medicare for you. You are responsible for payment for all services, excluding your adjustment fee, at the time of service. This would include X-Rays, Examinations, Supports, Nutrition and Therapies. We are able to submit to any secondary insurance as long as it automatically crosses over from Medicare, however, we recommend checking to find out what they will cover, as most insurance will follow Medicare guidelines of coverage. You are ultimately responsible for the payment of your bill. Medicare often limits spinal manipulation to 24 visits a year.

MEDICAL ASSISTANCE: We do accept assignment for Medical Assistance in our office. You are allowed 24 adjustments a year, not to exceed 6 visits per month. Medical Assistance does cover X-Rays and Manipulations, but do not cover Therapies, Exams, Nutrition and Supports and therefore, they are your responsibility. Please have your Medical Assistance card available at the time of your first visit.

NON-COVERED SERVICES: It is possible that some services rendered in our office may not be covered by your insurance. These may include but may not be limited to: Low level Laser Therapy, Strapping, Kinesio Taping, Nutrition Supplies, Pillows, Massage, etc. By signing below, you understand you are ultimately responsible for payment on any non covered services.

If you have any questions regarding our policy, we will be more than happy to assist you.

Patient Signature: _____ **Date:** ____/____/____