Precision Chiropractic

CONFIDENTIAL HEALTH QUESTIONAIRE

Name: _____ Date: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work: _____

Cell Phone: _____ *Cell phone **provider** (ex: Verizon, AT&T):_____

Email Address: _____

Would you like text and/or email appointment reminders? □ Text (2 hours prior) □ Email (1 day prior**)**

Birth Date: _____ Age: _____ □ Male □ Female

Occupation: _____ Employed By:_____

# of Children: _____ □ Single □ Married □ Divorced □ Widowed

Whom may we thank for referring you to us? _____

Which doctor were you referred to: □ Dr. Tomp □ Dr. Hoefer

Is this injury/illness related to an automobile accident? □ Yes □ No
If yes, please ask front desk for an auto accident questionnaire.

List your chief complaints in order of severity:

1) _____ For how long? _____

2) _____ For how long? _____

3) _____ For how long? _____

List Doctors consulted for this condition:

1) _____ Phone(optional): _____

2) _____ Phone(optional): _____

Have you ever had Chiropractic Care before? □ No □ Yes If yes, when? : _____

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Patient Signature: _____ Date: _____

Precision Chiropractic
FEE SCHEDULE

New Patient Consultation Exam & Report	$105.00 - $275.00
X-Rays	$40.00 - $440.00
Progress Exams	$85.00 - $200.00
Office Visits	$70.00 - $214.00
Therapeutic Massage	$75.00 - $150.00
Laser Therapy	$60.00 Per Region

Our experience has shown that it is wise to have a clear understanding with our patients as to our office policies and fees. Therefore this form has been prepared for your convenience and information. We offer several methods of payment for your chiropractic care. **Read carefully, Initial next to each plan and choose the plan that best fits your needs.**

____ Plan #1 – Cash, Check or Charge (Non-Insurance)- Fees are to be paid when services are rendered. The first adjustment is $125 and regular checkups are $70 paid at the time of service. Extended office visits are $85 for patients who have not been in for over 1 year or who require additional time. Notify the front desk when scheduling this type of appointment.

____ Plan #2 – Insurance/Care Credit- If you have insurance that covers Chiropractic Care, we will bill your out of network benefits directly. If your insurance company remits payment to you, we will collect the appropriate reimbursement. The insurance estimates we provide you are based on the information we receive. We never know exactly what they will pay until they process the claim(s). You may be responsible for the entire amount of your bill should your insurance not pay. **There will be a $10 fee per date of service if the wrong insurance information is supplied to our office and our billing department has to resubmit those dates to the correct insurance.**

____ Plan #3 - Auto Injury/ Personal Injury- We will need your Medpay benefits/health insurance information and attorney's name as well as their telephone number (if applicable). When working with an attorney on a lien we do collect copays at each time of service; $100 for the initial visit, $50 for the 1st Adjustment, and $20 for the follow up chiropractic visits as well as massage and laser. In the event the lien is voided or Medpay benefits are exhausted you are responsible for the bill in its entirety immediately. If while under treatment you decide to retain an attorney and your Medpay benefits are distributed to your attorney, you will be responsible for payment in full immediately.

NOTICE: ***Appointments that are not cancelled at least 24 hours prior (M-F 9-6pm) will be subject to a $35 no show/late cancellation fee.***
In the event your account is turned over to collections, there will be a 40% increase in your balance to cover service fees for the collection agency.

I qualify for and understand plan # ☐ **requirements.**

Signature_____ Date_____

Witness _____ Date _____

Precision Chiropractic

ASSIGNMENT OF BENEFITS and RELEASE OF AUTHORIZATION

I hereby authorize my insurance company to make payments to Alfred W. Tomp, D.C., Elizabeth S. Hoefer, D.C., or Tomp Chiropractic Corporation for chiropractic, massage or laser services rendered to me or my dependents, if applicable. Should my insurance carrier deny Precision Chiropractic payment, I understand that I am financially responsible for all charges. I authorize Precision Chiropractic to release any and all of my records to my insurer, or any third party payer, legally responsible for the payment of chiropractic, massage, or laser expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. I agree that a photocopy of this assignment shall serve in lieu of the original.

Patient Name (print clearly): _____

Patient Signature: _____ Date: _____

Insured Name (if different):_____

Witnessed by:_____ Date:_____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Precision Chiropractic we may use or disclose personal and health related information about you in the following ways;

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, agent, adjuster, HMO, PPO, or your employer, if they maybe responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used by our office only to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the notice to this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: If you would like further information about our privacy policies and practices please contact: You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services.

If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

Please list other people (*i.e. spouse, child, friend, personal trainer, attorney, massage therapist, acupuncturist, nutritionist)* with whom you authorize Precision Chiropractic to discuss your chiropractic care and health information. You may remove or add names to this at any time in writing.

Full Name (leave blank, add, or remove names at any time)	**Relation to you**

This notice is effective as of April 2003, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed)	Signature	Date

If you are a minor, or if you are being represented by another party

_____	_____	_____
Personal Representative (Printed)	Personal Representative Signature	Date

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

<u>Orthopedic & Musculoskeletal Symptoms</u>

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐Left ☐Right
- ☐ Upper Arm Pain ☐Left ☐Right
- ☐ Elbow Pain ☐Left ☐Right
- ☐ Forearm Pain ☐Left ☐Right
- ☐ Wrist Pain ☐Left ☐Right
- ☐ Hand Pain ☐Left ☐Right
- ☐ Hip Pain ☐Left ☐Right
- ☐ Upper Leg Pain ☐Left ☐Right
- ☐ Knee Pain ☐Left ☐Right
- ☐ Lower Leg Pain ☐Left ☐Right
- ☐ Ankle Pain ☐Left ☐Right
- ☐ Foot Pain ☐Left ☐Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

<u>Neurological Symptoms</u>

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

<u>Symptoms Associated with Injuries</u>

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

<u>Brain/Neuropsych/MTBI Symptoms</u>

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing