Name:

Dr. Milo Thurber
Dr. Allen Liebing
Dr. Alan Hanson

Advanced Family CHIROPRACTIC

Patient Application

PATIENT INFORMATION – MINOR/PEDIATRIC

LAST NAME	FIRST NAME	NICKNAME	SS#	SEX	BIRTHDATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	PARENT CELL PHONE

WHO MAY WE THANK FOR RECOMMENDING US?	E-MAIL ADDRESS

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE IN OUR OFFICE

PARENT/GUARDIAN INFORMATION

FATHERS NAME DOB:

ADDRESS (IF DIFFERENT FROM PATIENT'S)

CITY ST ZIP

EMPLOYER

ADDRESS

CITY ST ZIP

MOTHERS NAME DOB:

ADDRESS (IF DIFFERENT FROM PATIENT'S)

CITY ST ZIP

EMPLOYER

ADDRESS

CITY ST ZIP

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY/OCCUPATION

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

CELL PHONE	BUSINESS PHONE	SS#	E-MAIL ADDRESS

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EMERGENCY CONTACT INFORMATION

CONTACT PERSON IN CASE OF EMERGENCY

PHONE NUMBER RELATIONSHIP

Would you like to receive TEXT reminders for your appointments? YES NO

_____ _____

Parent/Guardian Signature Date Signed

Advanced Family CHIROPRACTIC

Patient Health History

Today's Date: ___

Height:_____ Weight:_____

Current Medications/Vitamins/Herbs/Minerals:

_____

Any Allergies:

_____

Surgical/Hospitalization/Broken bone History:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Please Describe Reason for visit

1._____

2._____

3._____

Symptoms developed from (circle one): Accident Illness Unknown

Symptoms are worse in the (circle one): Morning Afternoon Night

Symptoms have persisted for # ____hour(s) ____day(s) ____week(s) ____month(s) ____year(s)

When and how occurred? _____

Have you ever had this before? (circle one) No Yes When?_____

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Daily Habits

Eating habits (How often? How much? Difficulties?):

_____

Sleeping habits (How long? Frequency? Difficulties?):

_____

Extra Curricular Activities (Sports, Clubs, Instruments?):

_____

History of Labor:

Patient was delivered (circle one):

Vaginal (No Assistance) Vaginal (Vacuum or Forceps Assistance) Cesarean Section

Labor was: _____ (hours) Pushing Phase Lasted: _____(hours) _____(minutes)

Have you or your child ever been under chiropractic care before? Yes No

When was your last treatment?_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any disease or entity.
Initials _____	I may request a copy of the privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
Initials _____	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.
Initials _____	I grant permissions to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Initials _____	I understand that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
Initials _____	Per office policy, we take photos of each patient for their file. These are for office use only. Occasionally, other photos may be taken in our office, such as contest winners and for use on the Chiro Kids wall or social media. ___ I give permission to use these other photos for use in the office or social media.

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	___ I <u>do not</u> give permission for use of these other photos.
Initials _____	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Parent/Guardian Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Advanced Family Chiropractic *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Advanced Family Chiropractic disclosure of my individually identifiable health information to the individuals listed:

Name: _____Phone: _____

Name: _____Phone: _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

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We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying AFC in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by AFC until the termination request is received in writing and processed.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

Financial Agreement Health Insurance

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do not cover chiropractic care and this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you. A quote of **benefits** and/or authorization does **not guarantee payment** or verify eligibility. **Payment** of **benefits** are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service

Payment Arrangements:
We require that you pay your co-pay or estimated coinsurance at time of service. Any remaining portion of the bill is expected to be paid when payments are received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 3% applied per month. If you have a specific contracted amount for copayment that amount is due at the time of service.

Our office participates in an Auto-Debit program for collecting of all copays, coinsurances and balance. An authorization form will be required to be filled out in the office.

Assignment of Benefits:

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By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information:
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered at this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions you may have.

***When signing up for the Auto-Debit pogrom if there is a balance remaining on your account after the 5th of the month, your card will be automatically ran for any balance on your account up to $50.00 or the amount elected on your authorization form.**

I have read and agree to the above.

_____ _____

Signature Date