

RE-EXAM HISTORY

Date: _____

Name: _____ Social Security #: _____

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

Phone #'s: Home _____ Work _____ Cell _____

E-Mail Address: _____ Your Appointment Reminder: Home Work Cell

Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of Work: _____

Check One: Married Single Widowed Divorced Separated No. of Children: _____

Name of Emergency Contact: _____ Phone #: _____

Who is responsible for your bill: Self Spouse Parent Workman's Comp. Medicare Auto Insurance

Personal Health Insurance Company: _____ ID #: _____ Group #: _____

Other _____

MUSCULO SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- Scar from Surgical Procedure
- Sciatic Pain

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GENERAL CODE

Allergies: *please list*

- Loss of Sleep
- Fever
- Headaches

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FEMALES ONLY

When was your last period? _____

Are you pregnant? Yes No Maybe

If Yes or Maybe please check any of the following you are experiencing:

- Vaginal Bleeding
- Morning sickness (nausea or vomiting)
- Sciatic Pain
- Headaches
- Edema (swelling hands/feet)
- Pain or Discomfort

If yes, where and what kind? _____

Have you had Multiple Miscarriages? Yes No

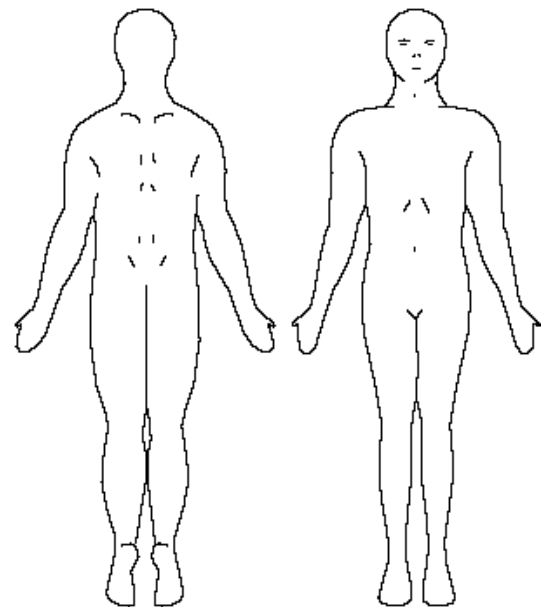
Other Concerns: _____

CPT CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes



Back

Front

Please outline on the diagram above the area of your discomfort.

Currently under medical care for the following: _____

Financial Agreement

The undersigned agree that **FULL PAYMENT** of the patient's portion of charges is **DUE AT THE TIME OF SERVICE**. Natural Care Chiropractic is required to collect co-pays and deductibles.

With respect to the remainder of the fee, we both acknowledge that YOUR INSURANCE POLICY is a contract between you and your insurance company. We are **NOT** a party to that contract unless we are a participating provider. We file claims as a courtesy for our patients.

IT IS TOO DISRUPTIVE TO OUR DELIVERY OF HEALTHCARE to be involved in disputes between you and your insurance company i.e., involving deductibles, co-payments, whether our services are covered charges, secondary insurance or your insurance company's definition of "usual and customary charges." Of course, we will provide all factual information as you have authorized us to do. You will need to do your part in pursuing your rights under your insurance contract.

NORMALLY, after this office receives insurance benefits and appropriate managed care or Medicare reductions have been applied, you will be asked to forward payment of any remaining balance due **WITHIN THIRTY (30) DAYS**. Reductions do not apply to co-pays and/or portions of balance applied to deductibles.

Insurance Companies make questionable, unexplained determinations of what are usual and customary fees. These are methods of cost containment. Rest assured, Natural Care Chiropractic's charges are well within the norm of usual and customary fee schedules.

Even though you have insurance coverage, **YOU ARE RESPONSIBLE FOR THE TIMELY AND FULL PAYMENT OF YOUR ACCOUNT**. Payment plans may be established for balances over \$500.00. Natural Care Chiropractic accepts cash, checks, Visa, MasterCard and Discover.

You may get an Explanation of Benefits Form (EOB) from your insurance carrier which indicates that our healthcare services are "Maintenance" "Not Medically Necessary" or "Not Covered" under your insurance policy. **YOU HEREBY ACKNOWLEDGE THAT YOU ARE STILL RESPONSIBLE FOR PAYMENT OF THESE SERVICES.**

IF WE RECEIVE A CHECK MADE PAYABLE TO YOU, for payment of our healthcare services rendered, you hereby authorize us to deposit said check when received.

Further, **IN THE EVENT THAT YOUR INSURANCE COMPANY PAYS YOU DIRECTLY** for our healthcare services, you hereby agree to immediately pay this office for same.

Natural Care Chiropractic, P.C., will charge a **\$30.00** fee for all returned checks due to "NON-SUFFICIENT FUNDS" or "CLOSED ACCOUNT" status.

Natural Care Chiropractic, P.C., reserves the right to turn all delinquent accounts over to a collection agency and /or pursue all legal avenues to collect its fees for healthcare services. You agree to pay all legal fees and other costs associated with our collection activity.

Finally, our professionals and the management of Natural Care Chiropractic believe that appointments are a mutual benefit to and a mutual obligation of both Natural Care Chiropractic and its patients. Appointments allow our professionals to provide individual, quality care to each and every patient and to provide adequate time to perform scheduled procedures. You are provided the reserved time and attention of the doctor, therapists and support staff, generally at a time that you have previously selected. Our office will call and verify your therapy appointment as a courtesy to you. You are responsible for arriving to your appointment on time. Notice must be given for any cancellation of therapy appointments at least 24 hours in advance. **SHORT NOTICE CANCELLATIONS** will be charged payable by you.

THANK YOU FOR YOUR COOPERATION, NATURAL CARE CHIROPRACTIC, P.C.

By: _____

Mark J. Freund, D.C.-Its President

I have read and BEEN GIVEN A COPY of this Natural Care Chiropractic, P.C., Financial Agreement. I hereby acknowledge that I have been given an opportunity to discuss the Financial Agreement with Dr. Freund. I understand that my signature on this Financial Agreement acknowledges my duties to pay as stated above and I hereby agree to the same. Natural Care Chiropractic, P.C., reserves the right to change its financial policy if it is deemed necessary.

____ **PRIVATE PAY** I will pay for all services, as they are rendered, and submit my own insurance claims.

____ **INSURANCE** I would like to assign my benefits to your office and have you submit my insurance claims for me, either in-network or out-of-network participation. I will pay for initial services rendered and any co-payment for subsequent services. If my deductible has not been met, I will pay the full amount until it is met. I understand that if my insurance company does not pay the balance within 45 days of submission, I am responsible for the entire balance overdue.

____ **AUTO ACCIDENT/ PERSONAL INJURY** I was involved in an automobile accident/personal injury and would like to assign benefits to your office and have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. I also understand that regardless of settlement, I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid within 45 days of claim submission, I will personally pay the entire overdue balance.

____ **WORKERS COMPENSATION** I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right as an Illinois citizen to have any bills incurred as a result of a work related accident paid for. I will read the Illinois worker's compensation pamphlet to better understand my rights. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this in the case, my rights may have been violated and I have the option to seek legal counsel.

____ **MEDICARE** I am a Medicare participant and will pay for services as they are rendered. I understand that your office does not accept assignment of benefits for Medicare but will submit all charges to Medicare for me.

Print Patient Name _____ Signature _____ Date _____