



PATIENT INFORMATION

Patient Name _____
SS# _____
Address _____
Apartment/Suite _____
City _____ State _____ Zip _____
Sex _____ Age _____ Birthdate _____
Marital Status (Circle One)
Married Widowed Single Divorced Separated
Ethnicity: (Circle One) *Hispanic Non-Hispanic*
Race: (Circle One) *White Black Asian or Pacific Islander*
Native American Multiracial Hispanic Other
Preferred Language: _____
How did you hear about our office? _____

CONTACT INFORMATION

E-mail _____
Cell Phone (_____) _____
Work Phone (_____) _____
Home Phone (_____) _____
Occupation _____
Patient Employer/School _____
Employer/School Address _____

Employer/School Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____
Relationship _____
Best Phone (_____) _____
E-mail _____

ACCIDENT INFORMATION

Is your condition due to an accident? _____
Date of Accident _____
Type of Accident: *Auto Work Home Other*
To whom have you made a report of your accident?
Auto Insurance _____
Employer _____
Worker's Comp Insurance _____
Other _____
Attorney Name (if Applicable) _____

Welcome to our Practice!

INSURANCE

Subscriber's Name _____
Subscriber's Birthdate _____
Relationship to Patient _____
Insurance Co. _____
Address _____
Phone # _____
Group # _____
Policy # _____
Any other Insurance? _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Matthew W. Ford, DC 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 disclose my health care 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 be in effect during all treatment at this office.

Signature of Patient, Parent, Guardian or Agent

Please Print Name of Signer

Date

Relationship to Patient

PATIENT'S INFORMED CONSENT

We are legally required to advise you of the following:

A doctor of chiropractic conducts a clinical analysis for the express purpose of identifying evidence of *Vertebral Subluxation Complex* (or simply *Subluxation*). Although chiropractors are experts in this type of diagnosis, they are not internal medicine specialists. They only provide adjustments to correct *Subluxation, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in the body's inability to express its maximum health potential.*

At this office we do not offer to diagnose or treat any condition or disease other than the *Subluxation*. If during the course of our examination we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area. We work with many other specialists to whom we can refer you.

We also must inform you that over the years there have been rare incidents of injury to the vertebral artery during the course of neck adjustments. Other slight risks with treatment include muscle strains and disc injuries. These injuries are VERY RARE (1 in every 1 – 1.5 million adjustments.) With these incidents a full recovery is anticipated. *Diagnostic tests are performed to minimize any risk.*

I have read and fully understand the above statements

Signature of Patient, Parent, Guardian or Agent

Date

PATIENT CONDITION

What brings you to our office? _____

When did your symptoms appear? _____

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

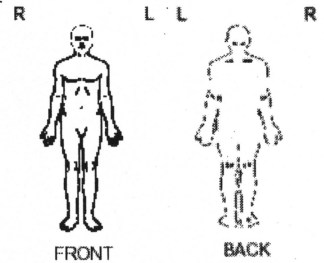
Describe your symptoms. (Burning, Sharp, Dull, Achy, Numb, etc.) _____

On a scale of 0 (no pain) to 10 (worst pain imaginable), how bad is it? _____

How often do you have this pain? _____ Is it getting better or worse? _____

Which activities do your symptoms interfere with? _____

When was the last time you really felt good? _____



HEALTH HISTORY

What treatment have you already received for your condition? _____

Name & address of other doctors who have treated you for this condition: _____

Have you ever had chiropractic care before? _____ Name of chiropractor: _____

What kind of maintenance program did your last chiropractor recommend? _____

Please circle any of the following you have now or have had in the past:

AIDS/HIV	Chicken Pox	High Cholesterol	Polio
Alcoholism/Addiction	Diabetes	Kidney Disease	Prostate Problem
Allergy Shots	Disk Bulge/Herniation	Liver Disease	Psychiatric Care
Anemia	Emphysema	Migraine Headaches	Rheumatoid Arthritis
Anorexia	Epilepsy	Miscarriage	Stroke
Arthritis	Glaucoma	Mononucleosis	Suicide Attempt
Asthma	Goiter	Multiple Sclerosis	Thyroid Problems
Bleeding Disorders	Gout	Osteoporosis	Tonsillitis
Breast Lump	Heart Disease	Pacemaker	Tuberculosis
Bronchitis	Hepatitis	Parkinson's Disease	Ulcers
Bulimia	Hernia	Pinched Nerve	Vaginal Infections
Cancer	Herpes	Pneumonia	Other _____

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking
Alcohol
Coffee/Soda
High Stress

_____ Packs per Day
_____ Drinks per Week
_____ Cups/Cans per day
Reason: _____

Are you pregnant? _____ If yes, Due Date: _____ If no, Last Menstrual Period: _____

Please list any surgeries/injuries/hospitalizations you have had:

Date	Reason	Resolved?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications:

Allergies:

Vitamins/Herbs/Minerals:



FORD CHIROPRACTIC + Regenerative Medicine

FINANCIAL AGREEMENT

Let's clarify the financial aspects of your care so we can direct our attention to helping you get well:

First Visit: On your first visit you'll meet the doctor to discuss your current health situation and to see if you're a good candidate for chiropractic care. If you are a candidate for chiropractic care, we'll conduct a thorough examination. This helps us identify the likely cause(s) of your problem. *Associated fees will include examination and necessary x-rays.*

Treatment Plan: On your second visit, (or at the end of your first visit - if there is time) we will tell you what we found, what we can do to help, how long it may take and estimate how much it will cost. We'll review other courses of action and offer you choices. There is no fee for the report of our findings and the treatment plan. *If you are accepted as a patient and choose to begin treatment there are fees associated with the chiropractic adjustment and therapeutic procedures.*

Regular Visit: If we accept you as a patient, your care will consist of a series of specific adjustments to restore proper function to your spine. Retraining the spine takes time. Each visit builds on the ones before. Some patients see rapid progress and others find their recovery slower. *Standard visit fees apply.*

Progress Examination: We'll monitor your progress with periodic exams every 4 – 6 weeks. These findings help document your progress. We may modify your visits based on these results. *There is a small additional fee for these progress exams.*

Cash Patients: Our office policy is to pay for the first visit at the time of service. After that you may pay weekly. If you require a payment plan, please talk with the receptionist *before* your appointment.

Health Insurance Patients: Most health insurance plans have an annual deductible, therefore we request you pay 100% of your charges until that has been satisfied, at which time assignment for direct payment of the benefits to this office will be made. We require a copy of your health insurance card, and if necessary a completed and signed insurance claim form. We will verify your eligibility for chiropractic benefits. *Please be advised that verification is not a guarantee of payment. All benefits are determined by the insurance company after the claim has been received and reviewed for medical necessity.*

Patients selecting this option understand that this office submits claims and awaits direct payment from the insurance companies as a courtesy and that it in no way relieves the patient of their financial obligation and responsibility to this office. *If your insurance denies or delays reimbursement to this office for any reason, we reserve the right to demand immediate payment in full from you, the patient.* Monitoring any policy limitations or changes is considered a responsibility of the patient.

Individual Consideration Contract: If there is financial hardship associated with receiving care in our office, payment will be in the following manner:

Billing: Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of \$20 our bank charges us for any returned checks. *You are financially responsible for all charges whether paid by insurance or not. If any incurred charges are not paid in a timely manner, an additional service fee equal to 35% of the outstanding balance may be added when submitted for collection.*

Agreement: This is the entire agreement between Ford Chiropractic and the patient below. I have read this agreement, understand it and agree with its provisions. I may have a copy of this agreement at any time upon request.

Patient or responsible party

Date

Medicare: *This office participates in Medicare's provider program. Payment for the patient portion is requested at the time of service and your claims will be submitted electronically by this office to Medicare. Spinal manipulation is the ONLY service that Medicare will cover. X-rays, examinations, therapies and supplies are not covered at this time. Please advise this office if you have secondary coverage with another health insurance carrier so that we may file this after Medicare as issued payment. Some secondary carriers MAY consider reimbursement of x-rays, examinations and therapies not covered by Medicare. I have been notified by my physician that he believes that, in my case, Medicare could deny payment for the services rendered. Procedures rendered in this office and fees for each have been explained. If Medicare denies payment, I agree to be personally and fully responsible for payment.*



PERSONAL INJURY FINANCIAL AGREEMENT AND POWER OF ATTORNEY

Let's clarify the financial aspects of your care so we can direct our attention to helping you get well:

First Visit: On your first visit you'll meet the doctor to discuss your current health situation and to see if you're a good candidate for chiropractic care. If you are a candidate for chiropractic care, we'll conduct a thorough examination. This helps us identify the likely cause(s) of your problem. *Associated fees will include examination and necessary x-rays.*

Treatment Plan: On your second visit, (or at the end of your first visit - if there is time) we will tell you what we found, what we can do to help, how long it may take and estimate how much it will cost. We'll review other courses of action and offer you choices. There is no fee for the report of our findings and the treatment plan. *If you are accepted as a patient and choose to begin treatment there are fees associated with the chiropractic adjustment and therapeutic procedures.*

Regular Visit: If we accept you as a patient, your care will consist of a series of specific adjustments to restore proper function to your spine. Retraining the spine takes time. Each visit builds on the ones before. Some patients see rapid progress and others find their recovery slower. *Standard visit fees apply.*

Progress Examination: We'll monitor your progress with periodic exams every 4 – 6 weeks. These findings help document your progress. We may modify your visits based on these results. *There is a small additional fee for these progress exams.*

Missed Appointments: If you miss your appointment without calling to reschedule, we may add a \$50 missed appointment fee to your account.

Billing and Payments: *You are financially responsible for all charges incurred in this office.* If you have been injured in an accident and do not carry personal health insurance or medical payments coverage on your automobile insurance, this office will await payment until 3rd party settlement is obtained, provided recovery is within SIX MONTHS of the last date of service. If you do not obtain settlement of recovery from the responsible party(s) within six months, or if litigation is eminent, you will be asked to make monthly payments. ***If any of the charges are submitted for collection, there will be a 35% service fee added to those charges.***

A state/county lien is automatically filed on all personal injury cases to insure payment to Dr. Ford from any/all responsible parties at the time of settlement for the services you receive. Your account will be charged any time this office is required to produce copies of medical records, mail any correspondence, i.e. certified mail, and all lien and court costs. Before this office can extend a patient credit, the patient MUST provide us with proof of third party liability or personal medical payments coverage.

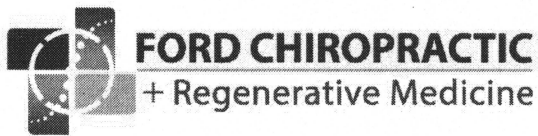
This office does not negotiate and will not reduce our fees for services rendered for personal injury cases. Therefore we will submit directly to ALL insurance companies to insure 100% reimbursement of services provided by this office. ***Any overpayments are refunded to the appropriate party when you are released from care. If health insurance is filed and it pays, the amount paid will be subrogated back to them, and a provider write-off will not be withheld.***

Limited Power of Attorney and Authorization to Release Medical Records: I authorize and direct all insurance companies, attorneys, etc. to make direct payment to Dr. Matt Ford for all monies due on my account. I also give permission to Ford Chiropractic to endorse my name to checks payable to both parties. I hereby authorize Ford Chiropractic to release any and all information about my medical condition and treatment to any persons, companies, corporations, insurance companies or estates so that the doctor may perfect his physicians lien.

Agreement: This is the entire agreement between Ford Chiropractic and the patient below. I have read this agreement, understand it and agree with its provisions. I may have a copy of this agreement at any time upon request.

Patient or responsible party

Date



HIPAA – Notice of Privacy Practice Acknowledgement

_____ (Initial) I have been provided a copy of Ford Chiropractic's Notice of Privacy Practice.

_____ (Initial) I have declined a copy of Ford Chiropractic's Notice of Privacy Practice.

HIPAA - Patient Consent to Leave Messages

Ford Chiropractic, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Ford Chiropractic from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Ford Chiropractic's physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Ford Chiropractic physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply)

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with _____ relationship _____

_____ with _____ relationship _____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

Patient's Name (Please Print)

Date of Birth

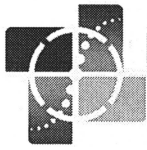
Patient's Signature

Date

Witness

Date

Notes: _____



FORD CHIROPRACTIC

+ Regenerative Medicine

Patient ID _____ Patient Name _____ Date _____

Automobile Accident Questionnaire

ACCIDENT INFORMATION:

Please explain in detail how your accident happened: _____

Date of Accident: _____ Time of Accident: _____ Number of people in the vehicle you were in: _____

Direction you were heading: _____ on _____ (street or highway)

Were you knocked unconscious? _____ Did you feel pain immediately after the accident? _____

You were struck from: _____ behind _____ front _____ left side _____ right side

Where were you sitting? _____ Wearing your seat belt? _____

Where were you taken after the accident? _____

Were you transported by ambulance? _____ Was a doctor consulted? _____ Was any treatment given? _____

Doctor's name: _____

Diagnosis given? _____

How long/How often did you see the doctor? _____

What were his/her recommendations? _____

Have you ever had any complaints in the involved area before? _____

Before the accident were you capable of working on an equal basis with others your age? _____

Are your work activities restricted as a result of the accident? _____

Since the accident are your symptoms improving, getting worse, or unchanged? _____

LIABILITY INFORMATION:

Driver of other vehicle (if any): _____

His/Her Insurance Company: _____

Address & Phone #: _____

Policy #: _____

Claim #: _____

Name of person who has made contact with you: _____

Name of driver of vehicle in which you were injured (self or other): _____

Insurance Company: _____

Address & Phone #: _____

Policy #: _____

Claim #: _____

Name of person who has made contact with you: _____

Have you retained an attorney? _____ If so, Name of attorney: _____

Attorney address & Phone #: _____



FORD CHIROPRACTIC

Accident & Injury Care Clinic

Patient ID _____ Patient Name _____ Date _____

Workers Compensation Questionnaire

INJURY INFORMATION:

What is your occupation/job title? _____

What type of work is involved? _____

Please explain in detail how your injury occurred: _____

Date of Injury: _____ Time of Injury: _____ Did you return to work? _____

Where did you feel pain immediately after the accident? _____

Have you consulted another doctor? _____

Did your employer send you to any other doctor? _____

Doctor's name: _____

What diagnosis was given? _____

How long/How often did you see the doctor? _____

What were his/her recommendations? _____

Did you lose time from work? _____

What medications are you currently taking? _____

Do any other diseases or injuries affect your employment? _____

If so, please explain: _____

In your work, do you have to favor any part of your body? _____

If so, please explain: _____

Have you ever had a Worker's Compensation claim before? _____

Before the injury, were you capable or working on an equal basis with others your age? _____

Are your work activities restricted as a result of this accident? _____

Since the injury, are your symptoms improving, getting worse, or unchanged? _____

Have you retained an attorney? _____ If so, Name of attorney: _____

Attorney address & Phone #: _____