Chiropractic Preliminary Information

Welcome to our office! It is well known that families who maintain strong, healthy, well-aligned spines have much improved health. People whose spines are not kept in proper alignment are much more likely to develop health disorders later in life such as arthritis, illness, pain, heart attacks, strokes, even cancer.

Name____________________ Nickname____________________

Address____________________ City,State, Zip____________________

Home Phone____________ Cell Phone____________ E-Mail____________________

Birthdate____________ Age______ SS#____________ Marital Status: M S W D

Employer____________ Work Phone____________ Occupation____________

Spouse Name____________ Spouse Birthdate____________ Spouse SS#____________

# of Children______ Names & Ages of Children____________________

Do you have insurance coverage? ☐No ☐Yes Insurance Co. Name____________________

1. Most people are referred to our office by a caring family member or friend. How did you find out about our office?

   ☐Referred by____________________ How known?____________

   ☐Office Sign/Drive By ☐Internet ☐Presentation ☐Newspaper ☐Other____________

2. Research shows that your spine should be checked regularly by a chiropractor. How many times have you visited a chiropractor in your lifetime?____________ How long ago?____________ ☐Never
3. When was your last complete spinal examination, including x-rays?____________ ☐Never
4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐Yes ☐No
5. Spinal misalignments can cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐Yes ☐No
6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐Yes ☐No
7. Poor posture leads to poor health and often indicates a spinal problem. Rate your posture: Poor - 1 2 3 4 5 - Excellent
8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days: Low - 1 2 3 4 5 - High
9. Please list the symptoms or condition that motivated today's appointment____________
10. List any other symptoms or conditions you experience or are currently taking medication for____________

    ____
11. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?____________
12. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐No ☐Yes
    Date of Incident____________ Details____________
13. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐Yes ☐No
14. If the doctor feels that chiropractic will help you, are you willing to follow his recommendations? ☐Yes ☐No

The above information is true and accurate to the best of my knowledge.

Patient Signature____________________ Date____________

Electronic Health Records Intake Form

In compliance with requirements of the Affordable Care Act

First Name:________________________________ **Last Name**:____

Email address: ____@_________________________________

Cell Phone #: __________________________**Carrier (Circle):** Verizon / Sprint / T-Mobile / AT&T /__________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text Message

DOB: _____/_____ /_______ Gender (Circle one): Male / Female **Preferred Language:** _________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked (means you have smoked less than 100 cigarettes in lifetime)

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander / Other __________________________ / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any PRESCRIBED medications? NO YES (complete below)

Medication Name	Dosage (ie. 5 mg)	Frequency (i.e. once a day, etc.)	Route (Pill, Capsule, Syringe, Suppository, etc.)

Do you have any medication allergies? NO YES (complete below)

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often redundant due to the nature and frequency of chiropractic care.)*

Patient Signature: ____Date:__________________________

For office use only

Height: ______'______” Weight:____________lbs Blood Pressure: L R S ________ / D________

Acknowledgement of HIPAA Notice of Privacy Practices

I hereby acknowledge that I have received and reviewed a copy of the HIPAA Notice of Privacy Practices from the office of Gary C. Stewart, D.C. (Stewart Family Chiropractic). The HIPAA notice is also available on our website at Stewart Family Chiropractic - HIPAA Notice of Privacy Practices.

______________________________	______________________________	______________
Name (Printed Please)	Signature	Date

If you are representing a minor, please list the minor's name(s) and your relationship.

____	______________
Minor's Name(s)	Relationship

Health Information Release - Designation of Relatives, Friends, and Other Caregivers for Healthcare Disclosure

I hereby authorize my Doctor and/or staff of Stewart Family Chiropractic to release any information concerning my condition, chiropractic care, or other healthcare information to persons involved with my healthcare decisions or payment.

I designate the following person(s) listed below as authorized to receive my personal health information. I may change the designees in writing at any time:

Name:______________________________ Relationship:______________________

*Name:*______________________________ *Relationship:*______________________

Name:______________________________ Relationship:______________________

____

Signature of Patient/Parent of Minor Date

Medicare Patients - Please Sign

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the office of Dr. Gary Stewart.

______________________________	______________________________	______________
Name (Printed Please)	Signature	Date

INSURANCE ASSIGNMENT POLICY

This office will assist the patient whenever possible in obtaining their benefits under their insurance policy.

IT MUST BE UNDERSTOOD:

1. Waiting for insurance payment is a courtesy and may be withdrawn at any time.
2. If your insurance carrier sends a payment directly to you, you are required to forward the check (endorsed over to the doctor), plus the explanation of benefits, or pay that amount to Dr. Stewart by personal check, cash, or money order within three business days of receipt or you will be legally responsible for the full amount of the bill. Failure to turn over insurance payments may result in your account being turned over for collection, and you will be responsible for collection fees as well. Please always bring in the explanation of benefits.
3. The patient must stay current with their percentage of responsibility. Payments toward deductible and insurance co-payments are due at the time of service or in advance.
4. If the patient discontinues care for any reason other than discharge by the Doctor, the bill is due and payable in full immediately, regardless of any claims submitted.
5. All deductible amounts must be paid prior to insurance submittal.
6. When this office receives an insurance check, if there is any balance due at that time, the patient will be notified and is required to pay the difference.
7. This office does not promise that an insurance company will pay the fees as charged.
8. In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not.
9. This office will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.
10. Insurance assignment may not be accepted until the patient attends the Doctor's Report and Report of Findings.
11. It is the patient's responsibility to resolve any issues (provide missing information, fill out questionnaire, update coordination of benefits, etc.) with the insurance carrier. If the patient fails to resolve any issues with the insurance carrier in a timely fashion and as a result a payment is not issued, patient will be legally responsible for the full amount of the bill.

I HAVE READ AND AGREE TO THE ABOVE INSURANCE ASSIGNMENT POLICY.

Patient/Responsible Party Signature ____ DATE______________________

Gary C. Stewart, D.C.
Stewart Family Chiropractic
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident, Medicare and Health Insurance

I hereby authorize and direct my Insurance Carrier(s), including Medicare, private insurance, group, accident, and any other health/medical plan to pay by check (or EFT) made out and mailed directly to:

Gary C. Stewart, D.C.
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

If my policy prohibits direct payment to my doctor, then I hereby instruct and direct the check to be made to me and mailed as follows:

C/O Gary C. Stewart, D.C.
43 Newark Pompton Turnpike
Riverdale, NJ 07457
(973) 835-5773

for the professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand and acknowledge that if my insurance carrier sends the payment directly to me, I shall turn over the insurance payment(s) to Stewart Family Chiropractic/Gary C. Stewart, D.C. within three business days or I will be legally responsible for the full amount of the bill. Failure to turn over insurance payments may result in my account being turned over for collection, and I will be responsible for collection fees as well.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster, or attorney involved in this case.

____ ____

Signature Patient/Responsible Party Date

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Witness