NEW PATIENT INFORMATION

Today's Date ___/___/_____

GENERAL INFORMATION

Patient Name_____ Nickname_____

Address_____City_____State_____Zip_____

Home Phone:( )_____Mobile ( )_____Work ( )_____

Date of Birth___/___/____ Age_____ Sex_____ SSN _____

Email Address_____ Marital Status_____ Spouse Name_____

Occupation_____ Employer_____

Emergency Contact_____ Emergency Contact Phone_____

Primary Care Physician_____ Address_____

PRIMARY INSURANCE INFO

Insurance Co. Name_____ ID#:_____Group #:_____

Insured's Name_____ Relation to You _____Insured's DOB _____

SECONDARY INSURANCE INFO

Insurance Co. Name_____ID#:_____Group #_____

Insured's Name_____ Relation to You _____Insured's DOB _____

Have you ever had chiropractic care?_____ When?_____

Doctor's Name_____ Were you satisfied?_____

If no, please list reasons for dissatisfaction_____

How did you hear about our office? Circle One

Friend **Relative** **Yellow Pages** **Internet** **Insurance Provider List** **Mail**

Which one of our patients should we thank for referring you?_____

NEW PATIENT INFORMATION (Page 2)

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

HEALTH HISTORY

For the conditions below, please indicate if you have had the condition in the past or if you presently have the condition:

Past	Present	Condition	Past	Present	Condition
o	o	Arthritis	o	o	Hip Pain
o	o	Back Curvature	o	o	HIV/AIDS
o	o	Blurred Vision	o	o	Jaw Pain/TMJ
o	o	Cancer	o	o	Loss of Balance
o	o	Chest Pain	o	o	Low Back Pain
o	o	Dizziness	o	o	Low Blood Press
o	o	Double Vision	o	o	Lung Problems
o	o	Drug/Alcohol Use	o	o	Mid Back Pain
o	o	Epilepsy/Seizures	o	o	Neck Pain
o	o	Fainting	o	o	Numb/Tingling
o	o	Foot or Knee Problems			Arms or Hands
o	o	Headaches	o	o	Numb/Tingling
o	o	Hearing Loss			Legs or Feet
o	o	Heart Attack	o	o	Ringing in Ears
o	o	Heart Problems	o	o	Scoliosis
o	o	Hepatitis	o	o	Shoulder Pain
o	o	High Blood Pressure	o	o	Skin Problems
o	o	Stroke	o	o	Swollen/Painful
o	o	Osteoporosis			Joints
			o	o	Upper Back Pain

Additional comments you would like the doctor to know:_____

_____

_____

NEW PATIENT INFORMATION (Page 3)

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

Please mark if you've ever had the following:

_____ **Back Surgery If so, what kind?**_____

_____ **Pacemaker**

_____ **Defibrillator**

_____ **Car Accident If so, when?** _____

_____ **Slip/Falls If so, what?**_____

_____ **Broken Bones If so, where?**_____

For Females: Are you or could you be pregnant?_____ If yes, how many weeks?_____

Assignment & Release- *By signing below, I authorize Lexington Family Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Lexington Family Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient.

_____
PATIENT'S NAME (PRINTED)

_____
PATIENT'S SIGNATURE (RESPONSIBLE PARTY)

_____
DATE

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

CURRENT COMPLAINT HISTORY SYMPTOM #1

Patient Name:_____ Today's Date:_____

Please list your present complaint(s)-If you have more than one area of complaint, list them in order of most severe to least severe.

Symptom 1._____**How long have you had this symptom?** _____

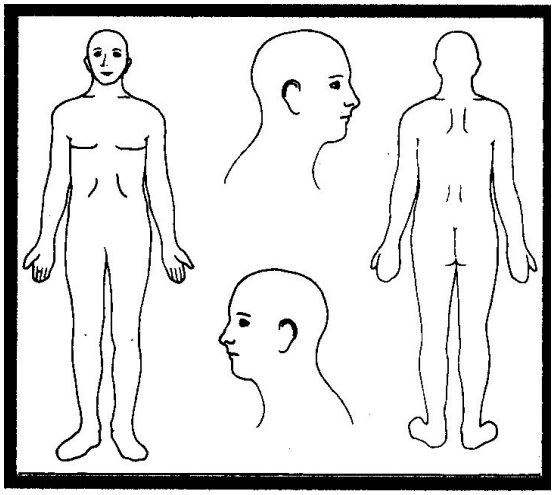
How did your symptom begin? □After a specific incident_____ □Gradually developed over time □Other_____

Was this symptom caused by (circle): Work Injury Car Accident Other Injury (List)_____

Description of pain or symptoms: □Sharp □Shooting □Dull □Burning □Ache □Numbness □Weakness □Tingling □Throbbing □Stiffness □ Stabbing □Other_____

SHOW US YOUR PAIN—USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

H= SHARP **G**= SHOOTING **B**= BURNING **A**= ACHE **N**= NUMBNESS
W= WEAKNESS **P**= PINS & NEEDLES **T**= THROBBING
F= STIFFNESS **S**= STABBING **O**= OTHER



On a scale of 0-10, with 10 being the worst, circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10

Does your pain move or radiate? □Yes □No Where_____

What makes your symptoms better? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest □Ice □Heat □Medication □ Massage □ Muscle Relaxers □Stretching □Other_____

What makes your symptoms worse? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest □Other_____

Check the best and worse time of the day for you pain:
Worse □First Awake □Morning □Afternoon □Evening □Nighttime □Other
Best □First Awake □Morning □Afternoon □Evening □Nighttime □Other

Frequency of pain or symptoms: □Constant (76-100%) □Frequent (51-75%) □Occasional (26-50%)
How many days on an average week are you in pain? (Please circle one) 1 2 3 4 5 6 7
How much time during the day are you in pain? □less than 1hr □1 to 6hrs □6 to 12hrs □12 to 18hrs □18 to 24hrs □24hrs

Has anyone treated you for this episode? □Yes □No If Yes, by whom?_____

Patient's Signature (Or Guardian):_____Date:_____

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

CURRENT COMPLAINT HISTORY SYMPTOM #2 AND #3

Please list your second complaint

Symptom 2._____**How long have you had this symptom?** _____

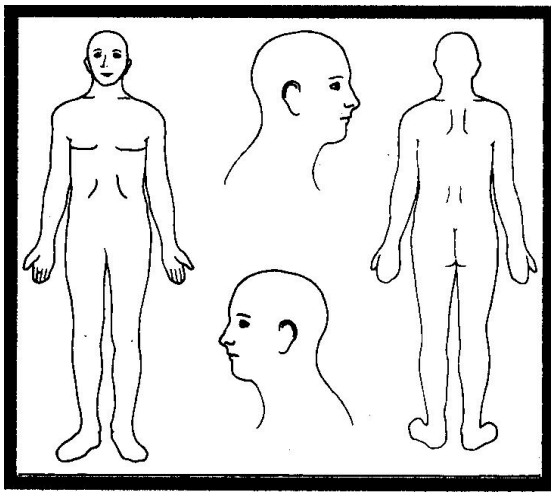
How did your symptom begin? □After a specific incident_____ □Gradually developed over time □Other_____

Was this symptom caused by (circle): Work Injury Car Accident Other Injury (List)_____

Description of pain or symptoms: □Sharp □Shooting □Dull □Burning □Ache □Numbness □Weakness □Tingling □Throbbing □Stiffness □ Stabbing □Other_____

SHOW US YOUR PAIN—USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

H= SHARP **G**= SHOOTING **B**= BURNING **A**= ACHE **N**= NUMBNESS
W= WEAKNESS **P**= PINS & NEEDLES **T**= THROBBING
F= STIFFNESS **S**= STABBING **O**= OTHER



On a scale of 0-10, with 10 being the worst, circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10

Does your pain move or radiate? □Yes □No Where_____

What makes your symptoms better? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest □Ice □Heat □Medication □ Massage □ Muscle Relaxers □Stretching □Other_____

What makes your symptoms worse? □Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Rest □Other_____

Check the best and worse time of the day for you pain:
Worse □First Awake □Morning □Afternoon □Evening □Nighttime □Other
Best □First Awake □Morning □Afternoon □Evening □Nighttime □Other

Frequency of pain or symptoms: □Constant (76-100%) □Frequent (51-75%) □Occasional (26-50%)
How many days on an average week are you in pain? (Please circle one) 1 2 3 4 5 6 7
How much time during the day are you in pain? □less than 1hr □1 to 6hrs □6 to 12hrs □12 to 18hrs □18 to 24hrs □24hrs

Has anyone treated you for this episode? □Yes □No If Yes, by whom?_____

Symptom 3_____

Patient's Signature (Or Guardian):_____Date:_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understan that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- For payment purposes, we may use the services of a billing service.

I consent to the use or disclosure of my protected health information by Lexington Family Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lexington Family Chiropractic. I understand that diagnosis or treatment of me by Dr. Heath Gallentine may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lexington Family Chiropractic is not required to agree to the restrictions that I may request. However, if Lexington Family Chiropractic agrees to a restriction that I request, the restriction is binding on Lexington Family Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lexington Family Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghous This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lexington Family Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lexington Family Chiropractic. This Notice of Privacy Practices also describes my rights and Lexington Family Chiropractic's duties with respect to my protected health information.

Lexington Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privac Practices, and will make available to all patients any and all revised and current notices.

_____ _____

PATIENT'S NAME (PRINTED) DATE

_____

PATIENT'S SIGNATURE (RESPONSIBLE PARTY)

FINANCIAL POLICY

Lexington Family Chiropractic strives to provide the best quality of services to our patients. This letter is to acquaint you with our office billing procedures.

An Overview of Our Billing Procedure

PATIENTS WITH INSURANCE

We participate with most major insurance plans. Each plan's chiropractic benefits are different, therefore it is your responsibility to know what is covered under your plan, your eligibility, and your benefits. Based on your chiropractic benefi through your insurance, it will determine your out-of-pocket expense.

***Please note:** We may get information from your insurance company regarding your chiropractic coverage, however, we are not responsible for any misinformation or incomplete information we receive from them. It is ultimately your responsibility to know your benefits. Benefits quoted to us are not a guarantee of payment. Also, your benefits can change throughout the year depending on your plan coverage—therefore, the amount you owe could change throughout the year. We do our best to provide you with the best information that we know at the time of service, however, any changes from that processed by your insurance company is not our fault or responsibility. **The coverage fror your insurance company depends upon the plan purchased by his/her employee, not the fees of the doctor.**

Each procedure done in our office, which includes an exam, x-rays, chiropractic adjustment, and therapies must be billed to the insurance company separately for reimbursement.

SECONDARY INSURANCE

It is your responsibility to provide us with any secondary insurance that you have. We will submit to your secondary once we receive your processed visits from your primary. Please note that most secondary insurances only cover coinsurances and may not cover copays and/or deductibles. The amount owed after processing through your secondary still remains your responsibility.

PATIENTS WITHOUT INSURANCE

Our office provides a "Time of Service Fee" for those without insurance. This fee is due in full at the time of the visit.

MEDICARE

We do accept assignment from Medicare. Medicare will only cover manipulation of the spine. Medicare pays 80% of the allowable fee once your deductible has been met. You are required to pay the deductible and the remaining 20%. Any non-covered services and fees will be discussed with you before those treatments occur. You will be required to sign an Advance Beneficiary Notice (ABN) regarding any non-covered services.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

We will submit your care to your auto insurance, however, we need your auto insurance company's name, address, claim adjustor's name and contact info. We also need your claim number to process the visits. Notify our office immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

"ON THE JOB" INJURY (WORKER'S COMPENSATION)

If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

Initial _____

FINANCIAL POLICY (CONT)

Your Responsibility As The Patient

As a patient at our office, you have a responsibility to do the following:

1) Patients **must provide us with a copy of your insurance card** for accurate billing. If your insurance changes, i is your responsibility to give us your updated card.
2) Patients are responsible for paying their copay at the time of service. Any quotes given to you from our staff are an estimate. Our office can **NEVER** guarantee insurance coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card or talk with someone in your HR department. **It is the patient's responsibility to be aware of how their insurance plans work and your benefit package. Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan.**
3) Patient's are responsible for paying all charges not covered by their health insurance plans.
4) The office will submit a claim up to two times per appointment; further insurance appeal will become the patient's responsibility.
5) **Since the agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care.** Your insurance company will let you and our office know if further information is needed from us (i.e: x-rays, written documentation, etc.)
6) **Patient's are responsible for balances in full 30 days after your first statement is sent.** The practice cannot carry balances longer than 90 days. **Balances over 90 days will be sent to collections**. In the event tha a patient's account is turned over to collections, 10% of that total will be added to the account. The patient is also responsible for all collection fees charged by the collection agency. It is understood and agreed that x-rays will not be released if there is a balance on a patient's account.
7) Patient's are responsible for all returned personal checks. **A service charge of $30 will be assessed for all returned checks.**

Assignment Of Benefits

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid healthcare plan, or Medicare, be made directly to:

Lexington Family Chiropractic, PLLC
Dr. Heath Gallentine
131 Prosperous Place Suite 15
Lexington, KY 40509

I have read, accept, and understand the above Financial Policy of Lexington Family Chiropractic and agree to all payment terms. My signature gives this office permission to give out any pertinent information to any insurance company, attorney, or adjustor who needs this information to facilitate the payment of a claim. A photocopy of this form shall be deemed valid

_____ _____

PATIENT'S NAME (PRINTED) DATE

_____

PATIENT'S SIGNATURE (RESPONSIBLE PARTY)

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

INFORMED CONSENT TO TREAT

I, _____, hereby request and consent to the performance of conservative, noninvasive chiropractic procedures, including spinal manipulation/adjustment and various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Gallentine and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Gallentine, including those working at Lexington Family Chiropractic whether signatories to this form or not.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include range of motion testing, muscle strength testing, palpation, orthopedic testing, neurological testing, and x-rays. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually preformed by hand but may be performed by a hand-guided mechanical instrument, such as an Activator. During an spinal adjustment, you may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. This sound is created by gas escaping the joints upon movement and is completely safe. Various physical therapy procedures, such as hot or cold packs, electric muscle stimulation, traction, stretching, and exercises may also be used.

Treatment Results And Risks

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, soreness, muscle spasm for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains, and physical therapy burns.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Alternative Treatments Available

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to: self-administered, over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; rest; steroid injections; bracing; surgery; no treatment. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

PATIENT'S NAME (PRINTED) **DATE**

_____

PATIENT'S SIGNATURE (RESPONSIBLE PARTY)