Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing ☐ Y ☐ N

Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Fainting/ Seizures/Epilepsy
☐ Y ☐ N Shingles
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Hepatitis
☐ Y ☐ N Anemia

☐ Y ☐ N Arthritis
☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Wrist Pain
☐ Y ☐ N Shoulder Pain
☐ Y ☐ N Arm Pain
☐ Y ☐ N Leg Pain
☐ Y ☐ N Lower Back Problems
☐ Y ☐ N Severe/ Frequent Earaches

☐ Y ☐ N Ringing in Ears
☐ Y ☐ N Severe/ Frequent Headaches
☐ Y ☐ N Diabetes/Tuberculosis
☐ Y ☐ N Dizziness
☐ Y ☐ N Emphysema/Glaucoma
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Artificial Bones/Joints
☐ Y ☐ N Cancer
☐ Y ☐ N HIV Positive/AIDS

☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Gout
☐ Y ☐ N Numbness, where?
_____
☐ Y ☐ N Tingling, where?
_____
☐ Y ☐ N Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Moss Chiropractic Clinic, P.C.
Financial Policy 2021

Moss Chiropractic is committed to providing you with the best possible chiropractic care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for our professional services.

- Our office contracts with a variety of insurance plans. If you are a member of one of these plans, our billing department will submit a claim for our services.
- It is your responsibility to:
    - Provide **all current insurance information** and present your insurance card at each visit.
    - Pay your full copay at each visit.
    - Pay any balance not covered by your plan including any deductibles, co-pays and non-covered services.
    - Know your own insurance benefits.
- If you have insurance for which we are **not** a contracted provider, we will bill the insurance as a courtesy. This does not apply to state funded Medicaid plans. A payment in full is expected at the time of service.
- Our office does not participate with state funded plans (unless it is secondary to Medicare). If it is secondary to Medicare, it is mandated assignment for the provider). The patient is responsible for the full charge at time of service.
- Our office **does not participate with United Healthcare**. The patient is responsible for the full charge at time of service.
- Unpaid patient balances will generate a patient statement for the balance due upon receipt of the statement. We appreciate your timely remittance.
- **If it is necessary** to obtain an authorization from your primary care provider, it is the patient's responsibility. Exception to this is Blue Care Network. As of August 1, 2015, our office is responsible to obtain a preauthorization for services.
- If the patient is a minor (17 years old or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payments due at the time of service. Bring the necessary authorizations and insurance cards.
- If you have any questions about your insurance coverage or limits, please direct those to the member service department at your insurance company. Contact information is found on the front or back of the insurance card. Additional concerns can be directed to our office @ 269.468.5775.
- If you receive a notice from the insurance company requesting information to expedite claims processing; please respond as soon as possible. No response from the patient may result in claims denial and put the date of service outside of the filing limitations granted by the insurance company. (Clean claim 30 days)
- **Return checks** will assess a $35 charge.
- **Missed massage appointments** assess a charge of $30.
- Our office utilizes Allied Collection Agency for past due patient balances.

We strongly believe that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to our office @269.468.5775.

Assignment

I authorize release to any third party payers such as an insurance company or governmental agency, any medical information contained in my records when such material is required in connection with determining a claim for payment. I hereby assign all payments for medical services for myself and/or dependent to Moss Chiropractic, I agree to pay for any charges not covered by my insurance plan.

Name _____ **Date** _____

Moss Chiropractic Clinic, P.C.

Acknowledgement of Receipt of Privacy Policy

2020-2021

I acknowledge Moss Chiropractic Clinic, P.C. the office of David E Moss, D.C. "Notice of Privacy" has been provided to me. I understand that I have the right to review notice of privacy practices prior to signing this document. 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 healthcare operation of Moss Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Moss Chiropractic is also provided on request at the main desk of the practice.

Moss Chiropractic Clinic, P.C. reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised "Notice of Privacy Practices" by calling the office and requesting a revised copy be sent to me in the mail or for asking for one at the time of my next appointment.

Name _____ **Date** _____
(Signature of patient or personal representative)

_____
(Printed name of patient or personal representative)

_____
(Description of personal representative's authority)

Moss Chiropractic Clinic, P.C.

429 N Paw Paw Street – Coloma, MI 49038

Consent to Treat a Minor

I (We) being the parents(s), guardian or custodian of _____

A minor, the age of _____, do hereby authorize, request and direct Dr. David E. Moss and/ or Dr. Olivia Knight, to perform the following procedures(s) on the person of said minor.

- Chiropractic manipulations (including distraction)
- Therapy services i.e., extremity adjustment(s)
- Therapy services i.e., ultrasound w/ topical

All services provided as necessary to meet the health care needs of the above named patient.

_____

(Parent, guardian or custodian – signature only)

_____

(Parent, guardian or custodian – signature only)

_____

Witness (signature and date)

Updated 07.01.2021