

**WELCOME TO
CROSSROADS WELLNESS & REHAB**

Date: _____ Name: _____ Home Phone: (____) _____

E-Mail: _____ Cell Phone: (____) _____

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

Date of Birth: ____ / ____ / ____ Age: _____ SSN: _____ DL: _____ State: _____

Occupation: _____ Employer: _____ Work Phone: (____) _____

Occupation Address: _____
Street City State Zip

Single Married Other Spouses Name: _____

Nearest Relative Not Living With You: _____

Relationship: _____ Phone: (____) _____

Who (or what source) referred you? _____

Insurance Information

Name of Health Insurance Company: _____

Insurance Holder's Name: _____ Date of Birth: ____ / ____ / ____ SSN: _____

Insured's Employer _____

Relationship to You: Self Spouse Mother Father

Is this complaint due to a work related or auto accident: YES / NO

Any time lost from work due to this illness or accident: YES / NO From: _____ To: _____

I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on:

_____ on my home answering service.

_____ on my work answering service.

_____ with: (full name of person: _____.)

Signing below verifies your consent to the rendering of care including treatment and performance of diagnostic procedures.

Patient Signature: _____ Date: _____

If Minor, Parent/Guardian Signature of Consent: _____ Date: _____

Office Witness: _____ Date: _____ Acct: _____

CASE HISTORY FORM

PLEASE INDICATE **Y** (YES) OR **N** (NO) FOR ALL SYMPTOMS/CONDITIONS
YOU CURENTLY HAVE OR HAVE HAD IN THE PAST.

<input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N Polio <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N Whooping Cough <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Cancer <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N Seizure <input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorders <input type="checkbox"/> Y <input type="checkbox"/> N Nervous <input type="checkbox"/> Y <input type="checkbox"/> N Asthma <input type="checkbox"/> Y <input type="checkbox"/> N Paralysis <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness <input type="checkbox"/> Y <input type="checkbox"/> N Are you HIV positive	<input type="checkbox"/> Y <input type="checkbox"/> N Forgetfulness <input type="checkbox"/> Y <input type="checkbox"/> N Headaches <input type="checkbox"/> Y <input type="checkbox"/> N Confusion/ Depression <input type="checkbox"/> Y <input type="checkbox"/> N Fever <input type="checkbox"/> Y <input type="checkbox"/> N Numbness/ Tingling <input type="checkbox"/> Y <input type="checkbox"/> N Anemia <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue <input type="checkbox"/> Y <input type="checkbox"/> N Loss of Sleep <input type="checkbox"/> Y <input type="checkbox"/> N Poor/Excessive Appetite <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Thirst <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Nausea <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea <input type="checkbox"/> Y <input type="checkbox"/> N Constipation <input type="checkbox"/> Y <input type="checkbox"/> N Loss of Bowel Control <input type="checkbox"/> Y <input type="checkbox"/> N Are You Pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Cramps <input type="checkbox"/> Y <input type="checkbox"/> N Black/Bloody Stool <input type="checkbox"/> Y <input type="checkbox"/> N Loss of Bladder Control <input type="checkbox"/> Y <input type="checkbox"/> N Discolored Urine <input type="checkbox"/> Y <input type="checkbox"/> N Painful/Excessive Urination <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> N Blood Pressure Problems <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heartbeat <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems <input type="checkbox"/> Y <input type="checkbox"/> N COPD <input type="checkbox"/> Y <input type="checkbox"/> N Congestion <input type="checkbox"/> Y <input type="checkbox"/> N Stroke Women: _____ _____ _____
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Date: Last Mammogram _____
 Date: Last Period _____
 Date: Last Pap smear _____

Do you smoke? Y N Do you drink alcohol? Y N Do you do recreational drugs? Y N
 How much? _____ How much? _____ How much? _____

Who have you seen as your primary care/medical doctor? _____

Location: _____ Telephone: _____

Past Hospitalizations/ Surgeries/ Fractures (list date and reason)
 Please List:

Date of Last: Pneumovax _____ TB Skin Test _____ Cholesterol _____ Eye Exam _____
 Tetanus Shot _____ Results _____

List any chronic diseases you may have: _____

Are you currently taking any prescription drugs? Y N
 Please List:

Dr. Signature _____ Date _____

Patient Name: _____ DOB: _____ Pt. Acct. #: _____

Patient Health Questionnaire - PHQ

Patient Name _____

Date _____

1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms?

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

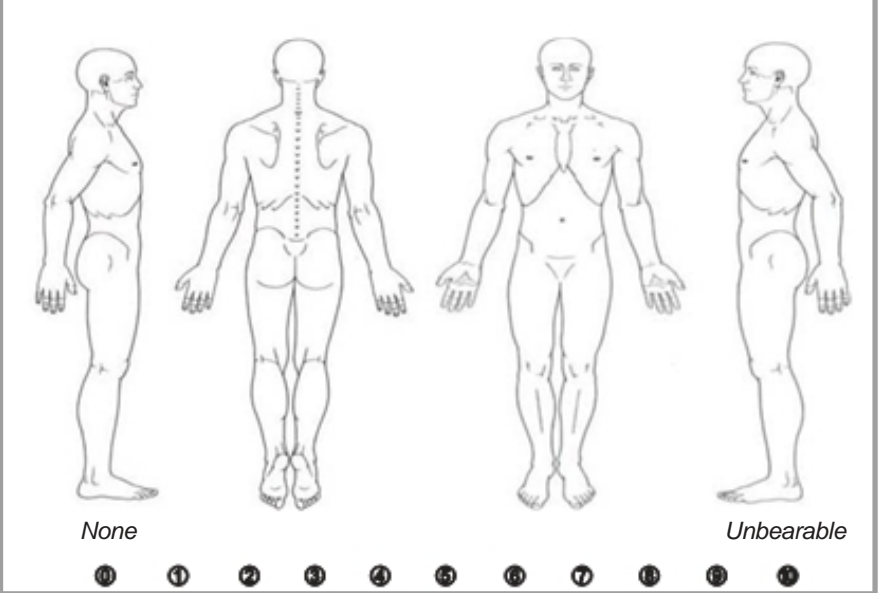
- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

10. What is your occupation?

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other
- ⑨ Full-time
- ⑩ Part-time
- ⑪ Self-employed
- ⑫ Unemployed
- ⑬ Off work
- ⑭ Other

Indicate where you have pain or other symptoms



Patient Signature _____

Date _____

Crossroads Family Chiropractic

OFFICE & FINANCIAL POLICY

Thank you for choosing our office for your health care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of our office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment plans are available upon signature of agreement. We offer Care Credit, a no interest financing program designed for your convenience.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

“ON THE JOB” INJURY (Worker’s Compensation)

If you are injured on the job, your care could be paid for under your employer’s Worker’s Compensation insurance. 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 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor’s Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six (6) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met.

You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

(CONT)

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for BCBS, United Health Care, Cigna, Medcost and many more.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

APPOINTMENTS

In order to provide the most efficient care; we work within an appointment system. Our office hours are M, W, TH 7:30a-6:30p, T 3:00p-6:30p and F 7:30a-12:00p with lunch daily from 12:00p-2:30p. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We are available when emergencies arise and will do our best to give prompt consideration as needed. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your scheduled appointment, we may need to reschedule to allow time for your treatment.

CANCELLATION POLICY

I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least twenty-four (24) hours in advance of my scheduled appointment time. Please note schedule changes will be accepted only during regular office hours. I am aware that I may be charged a fee if I do not provide twenty-four hours notice of cancellation or do not show up for an appointment. The fee will vary depending on the amount of time scheduled and will not be less than \$50.00. If you fail to show up for two (2) appointments, we may not be able to schedule you for future appointments.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Crossroads Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Crossroads Family Chiropractic and my insurance company. I request that Crossroads Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Crossroads Family Chiropractic that fees will be due and payable immediately. I understand that this office offers flexible payment plans to fit in my budget. Once I have chosen a payment option I agree to the terms and understand that in the event of default on a payment plan my balance will be due in full and care will be discontinued until payments are up to date. Any balance past due more than 30 days will be subject to 1.5% interest per month.

Patient's signature (or guardian if patient is a minor)

Date

Witness

Patient's Name: _____

DOB: _____

ACCT: _____