James Chiropractic
4249 N. St. Peters Pkwy. Suite A
St. Peters, MO 63304

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date_____________Name____
Nickname________________Address____
City______________________State________Zip___________Date of Birth_______________Age______
Gender (check one) ___M ___ F Marital Status (check one) ___ Married ___Widowed ___Other
___ Single ___ Divorced

Race (check one)
___White ___Black/African American ___Hispanic ___Asian
___ Other________________________________ ___I choose not to specify

Multi-Racial (check one) ___Yes ___No ___Unknown ___ I choose not to specify

Ethnicity (check one) ___Hispanic or Latino ___Not Hispanic or Latino ___I choose not to specify

Preferred Language (check one)
___English ___Spanish ___ Other__________________ ___I choose not to specify

Home Phone________________Work Phone___________________Mobile Phone__________________
Social Security#_______________________ E-Mail ____
Occupation:_______________________Employer____
Employer Address____
City_____________________________________State_____________________Zip_______________

Which method do you prefer for us to communicate with you (check one):
___ Home Phone ___Work Phone ___Mobile Phone

Employment Status (check one):
___Employed ___FT Student ___PT Student ___Other ___Retired ___Self Employed

Who referred you to this office?____

Spouse Info: Name_______________________________Number of children/ dependents____________
Date of Birth____________________Employer____
Address____

Insurance Info:
Primary Carrier:_________________________________Secondary______________________________

Is this an accident?______Yes_____No If so, date of injury____________________________________
( )Auto accident ( ) State Compensation ( ) On the Job Injury ( ) other

Have you reported a work related injury to your employer? ____yes ____no

How did you get injured?____

Name and Address of Attorney advising you____

Patient Name:________________________________**Date:**_________________________________

List your main complaints in order of severity:
1. _____________________________________For how long?________# previous incidents________
2. _____________________________________For how long?________# previous incidents________
3. _____________________________________For how long?________# previous incidents________

Have you ever had Chiropractic care before?_____If so when?__________________________________
By whom?___________________________For what condition?________________________________

List other Doctors consulted on above complaints:
1. ______________________________________Address___________________________________
2. ______________________________________Address___________________________________

Have you had this or a similar condition in the past?____yes____no

Is this condition interfering with your____work_____sleep____daily routine

What do you believe is wrong with you?____

Do you currently **smoke tobacco** of any kind? ___Yes ___Former Smoker ___Never been a smoker
If yes, how often do you smoke: ___Current every day smoker ___Current smoker sometimes

Alcohol use: Y/N _____per day **Drugs:** Y/N _____ per day

How many caffeinated drinks do you consume per day?
___None ___less than 3 ___3-6 ___more than 6

Exercise: ____Never ____Daily ____Weekly ____Occasionally Other:__________________

NOT INCLUDING YOURSELF: Are you aware of any inherited diseases in your family, including High Blood Pressure, Heart Disease, Stroke, Heart Attack, Diabetes and/or Cancer? ___Yes No___ **IF YES, PLEASE LIST DISEASE & RELATIONSHIP TO YOU**:

1)_______________________________________ 3)_______________________________________
2)_______________________________________ 4)_______________________________________

Have you ever been **hospitalized FOR ANY REASON**? ___NO ___YES (List approximate dates/reason)
____ ____
____ ____

Current Medications, including **Strength, dosage, frequency, and Prescribing Physician**, if known.
If there are no current medications, check here: ___
1)_______________________________________ 5)_______________________________________
2)_______________________________________ 6)_______________________________________
3)_______________________________________ 7)_______________________________________
4)_______________________________________ 8)_______________________________________

Patient Name:____**Date:**_____________________________

List any known **ALLERGIES AND REACTIONS** you have had to any medications.
If no allergies are known, check here:___
1)____________________Reaction_____________ 3)__________________Reaction______________
2)____________________Reaction_____________ 4)__________________Reaction______________

Briefly list your **MAIN HEALTH PROBLEMS**:
____
____

Has any doctor diagnosed you with **HYPERTENSION (High Blood Pressure)** presently? ___Yes ___No
If yes, describe: ____

Has any doctor diagnosed you with **DIABETES** presently? ___Yes ___No
If yes, what type? ___Type I ___Type II

Past History:
Please list **ANY SURGERIES** that you have had, including **approximate DATE(S):**
______________________________________ _______________________________________
______________________________________ _______________________________________

Please indicate whether you have had **ANY** of the following, including **DATE**, **SEVERITY** and **TYPE OF INJURY**:
Motor vehicle accident:____
Serious Falls:____
Fractures:____
Tumors:____
Cosmetic Surgeries:____
Date of last menstrual period:____
Other:____

Have you had **ANY X-ray, CT Scan, or MRI in the past two (2) Years?** ___ YES ___NO
If yes, please list **dates and where the x-rays were taken**____

***If your medical records are requested by anyone **without a Release of Information signed by You,** they will be required to provide the answer to one of the questions below:

Verification Question (choose only one question by checking the question, then give the answer to that question)
___What is the name of your favorite pet? ___In what city were you born?
___What High School did you attend? ___What is your favorite movie?
___What is your mother's maiden name? ___On what street did you grow up?
___What was the make of your first car? ___When is your anniversary?
___What is your favorite color?

Verification Answer to the Chosen Question:____

REV:11/18/15

James Chiropractic
Financial Policy

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic center. **We are not certain if your insurance covers chiropractic, although most policies do provide coverage**. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage or co-pay as stated in your policy. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. We allow one resubmission of claims at no charge. If your insurance company fails to process the claims after a second submission you will be required to pay for services and seek reimbursement from your insurance company. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible in the event that your insurance company denies payment. We will assist you in verifying your insurance coverage; however, it is your responsibility to know the provisions of your particular policy. When all insurance checks have been received, we will refund any overpayment to you.

PATIENTS WITHOUT INSURANCE: An increasing number of patients do not have insurance, or have plans with limited coverage, such as catastrophic policies. We realize that no one wants to build up a large bill. Therefore, we have several plans so those patients may receive complete care without undue financial difficulty. Of course we are always happy to accept cash, your personal check, MasterCard, or Visa. We request that 100% of the first visit be paid at the time of the first visit.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid **as long as you are an active patient and do not have major medical or medical payments coverage**. We do not accept provider discounts because the liability carrier or medical payments coverage is the primary insurance company all others are secondary. If you suspend or terminate care any fees and services are due immediately. We will contact your attorney and insurance companies to begin settlement procedures upon release from active care. If your case is not settled within 90 days from your release, we will require you to make partial payments of 20% of your outstanding balance for the next five (5) months. At any point settlement is reached, your account is due and payable in full immediately.

MEDICARE: We do accept assignment from Medicare. The check is usually sent directly to us in payment of services that Medicare will cover. For chiropractors, this includes **only** manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. The patient is also responsible for payment of all non-covered services when they are rendered. Subsequent services will be payable at each visit unless other arrangements are made. Our office will complete the necessary forms and file them with the Medicare provider at no charge. We allow one resubmission of your claim at no charge. I request payment of government benefits either to myself or to the party who accepts assignment below.

"ON THE JOB INJURY": Worker's Compensation pays in full for chiropractic care **when approved by your employer**. 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 the proper information, or if settlement has not been made within three (3) months, or if you suspend or terminate care, any fees for services are due immediately.

******Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics, and nutritional supplements, etc. at the time they are provided to you.

** If my account is turned over to collections, all collection fees will be in addition to the account balance.

Note: Your health information will be kept confidential. Any information we collect about you will be kept confidentially in our offices. If a claim is submitted to an insurance provider, your health information may be shared with the insurance company. The insurance company will keep your information confidential.

Signature_________________________________ **Date**_____________________________

Charleston Square Chiropractic LLC d/b/a James Chiropractic

4249 N. St. Peters Parkway, Suite A

Phone: (636) 441-9240 St. Peters, Missouri 63304 Fax: (636) 441-2224

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from Charleston Square Chiropractic LLC dba James Chiropractic ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims on my and/or my dependents' behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan; (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance olicy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of the Assignment/Authorization shall be as effective and valid as the original.

____ ________________________

Patient Date

____ ________________________

Policyholder/Insured Date

Charleston Square Chiropractic d/b/a James Chiropractic

Effective Date: 11/04/2015

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

This summary of our Notice of Privacy Practices is posted for your convenience. Printed copies of our full Notice of Privacy Practices are available near this posted summary. You are welcome to read the full Notice of Privacy Practices and take a copy with you.

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may use and share your information in order to:

1. Treat you which means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be referring you to another physician for a second opinion.
2. Provide information so we can receive payment for your health care services.
3. Manage the health care quality and business operations of our organization.

You have the right to:

1. Receive a full copy of our Notice of Privacy Practices.
2. Ask us to restrict information we share including restriction of information to your insurance carrier for care that you or someone other than the insurance carrier pays for out of pocket.
3. Ask us to communicate confidentially with you in a way and at a place you prefer.
4. Inspect and get a copy of medical information used to make decisions about your care.
5. Ask us to correct information in your medical record if you believe it is not correct.
6. Find out to whom we have disclosed your medical information.
7. Complain to us or the Secretary of Health and Human Services without fear of retaliation if you believe your health privacy rights have been violated.

We must:

1. Maintain the privacy and security of your protected health information as required by law.
2. Provide you with a notice describing our legal duties and privacy practices - our Notice of Privacy Practices - and follow the terms of our current Notice of Privacy Practices. We may change the Notice of Privacy Practices from time to time. Any change will be made available and will apply to prior information we may have about you.
3. Notify you if there is a breach of your unsecured protected health information.

For more information:

For more information about the matters covered by this Summary or about our Notice of Privacy Practices or to make a complaint that your privacy rights have been violated, contact our Privacy Official listed below. If you wish, we will provide you with a form to make a complaint to us. You may also make a complaint to the Secretary of Health and Human Services and our Privacy Official will explain how to do that.

We respect you and your privacy and will never retaliate against you if you file a complaint.

Privacy Official of Charleston Square Chiropractic d/b/a James Chiropractic
Telephone: 636-441-9240
Office address:
4249 N. St. Peters Pkwy.,
St. Charles, Missouri, 63304

Charleston Square Chiropractic d/b/a James Chiropractic

Effective Date: 11/04/2015

We are required by law to provide you with a copy of our Notice of Privacy Practices, which explains how we may use and disclose your health information and your rights and our legal obligations with respect to your health information.
By signing this form you acknowledge you have received our Notice of Privacy Practices.

Today's Date: _______________

You may refuse to sign this Acknowledgement, if you wish.

Acknowledgement of Receipt of Notice of Privacy Practices by Individual

My Name: __________________________________

Birth Date: ____/____/______ Last 4 digits of my Social Security # ____ ____ ____ ____

Please sign on the line below to confirm that today we provided you with our Notice of Privacy Practices and to acknowledge you have received our Notice of Privacy Practices

____

My Signature

Acknowledgement of Receipt of Notice of Privacy Practices by Personal Representative for Individual

Name of Individual: ____

Name of Personal Representative: _____________________________

Relationship of Personal Representative to Individual and Authority to Act for Individual:

____

Please sign on the line below to confirm that today we provided you with our Notice of Privacy Practices for the Individual named above and acknowledge its receipt for the Individual

____

Signature of Personal Representative

For Office Use Only

If Acknowledgement of Receipt of Notice of Privacy Practices is signed
Check 1 or 2

1. ____ Identity of the Individual verified.

2. ____ If Personal Representative signed on behalf of the Individual
Identity of Personal Representative and Authority to Act for Individual verified.

If Acknowledgement of Receipt of Notice of Privacy Practices is not signed,
Check 3 and explain briefly below:

3. ____ We made a good faith effort to obtain a written acknowledgment of receipt of our Notice of Privacy Practices but could not because:

Confirmed for Charleston Square Chiropractic d/b/a James Chiropractic

by: _________________________ _______________________________ ___________

Signature Printed Name and Title

Patient Name:___________________________________ **Date:**___________________________

(Office Use Only)

Doctor notes:

Height:	Weight:	BP:	P:

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Rev. 8/25/14