Lett Chiropractic Center 1509 Hardy Street Hattiesburg, MS 39401

PATIENT INFORMATION AND FINANCIAL POLICY

ABOUT YOU

Name_____ Social Security Number____/____/____

DOB____/____/____ ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

Home Address_____
City State Zip

Mailing Address_____
City State Zip

Telephone Numbers: Home _____ Work _____Ext_____ Other _____

❑ Employed ❑ Student (Full-Time) ❑ Student (Part-Time)

Occupation_____ Employer_____

Spouse_____ DOB____/____/____ Social Security Number____/____/____

Spouse's Occupation_____ Spouse's Employer_____

Referred By_____ ❑ Yellow Pages ❑ Location ❑ MD/DC ❑ Other_____
Person

FINANCIAL POLICY

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time.

Please check the appropriate method of payment:

❑ **Private Pay** - Payment is expected at the time of service. We accept cash, check, Visa, Discover and MasterCard . **We offer a 15% Time of Service discount for fees paid at time of service (supplies/DME not included). This discount excludes Federal Entitlement recipients and applies to non-billed services only.**

❑ **Insurance** - As a service to you, this office will file your insurance claim for you. Please provide the necessary information prior to treatment. Please note, if you take advantage of our Time of Service Discount, we will be unable to file your insurance claim. Health insurance policies are an arrangement between an insurance carrier and yourself. Though we file your claim, you are personally responsible for payment for all services rendered . We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information. In the event your insurance company disputes or rejects the claim, it will be your responsibility to pay the charges and pursue reimbursement from the insurance company. **Payment for deductibles, co-pays, and non-covered services is expected at the time of service.**

❑ **Medicare/Medicaid** - This office accepts assignment on Medicare and Medicaid covered services. However, **you are responsible for non-covered services, co-pays and deductibles.**

❑ **Personal Injury** - We will be willing to wait up to 3 months for payment (excluding supplies/DME, which must be paid at time of service) provided there is a reasonable chance that payment will be made from insurance proceeds, or settlement of a liability claim. *However, if the insurance company or attorney refuses to protect the interest of the doctor, or if it appears that there is no attorney or insurance coverage, you must pay for services on a current basis.* Also, the **balance must be paid in full within 48 hours of settlement of your claim.**

❑ **Worker's Compensation** - If you are seeking treatment for an injury received on the job, please provide the necessary information concerning your employer's Worker's Compensation insurance prior to treatment.

Insurance and/or Attorney Information

Insurance Company_____ ID#_____ Group/Policy #_____

Insured's Name_____ Relation_____ Employer _____

Insured's Date of Birth____/____/____ Insured's SSN____/____/____

If an attorney represents you in this health matter, please complete the following:

Attorney Name _____ Telephone # (____)____-____

I have read, understand, and agree to this financial policy and maintain that all information is correct to the best of my knowledge.

_____ _____ _____ _____

Patient/Guardian Signature Date Staff Signature Date

Revised 03/2003

CONFIDENTIAL CASE HISTORY

Name_____ DOB____/____/____

Past Chiropractic Care? ❑ No ❑ Yes Doctor's Name_____ Results_____

REASON FOR THIS VISIT

Major Complaints & Symptoms: _____

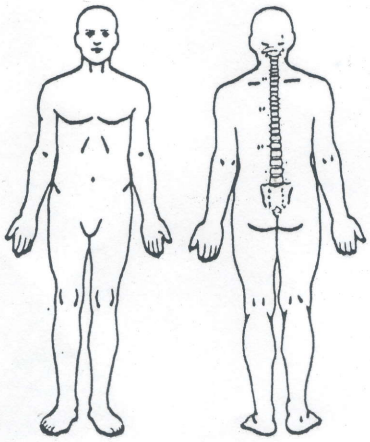
_____

This onset: Began ____/____/____ **Is this problem due to an injury?** ❑ No ❑ Yes … ❑ On the Job ❑ Auto Accident ❑ Other

Same or Similar Condition in the Past? ❑ No ❑ Yes Explain_____

Dr./Staff Notes

Indicate your areas of pain on the diagrams below:



Dr./Staff Notes

Rate your discomfort on the pain scales below. (Zero = no pain, 10 = worst pain possible)

Neck-Shoulder-Arm-Hand Pain 0 1 2 3 4 5 6 7 8 9 10

Since onset, pain is: ❑ Better ❑ Worse ❑ Unchanged

Occurs: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Lasts: ❑ Minutes ❑ Few Hours ❑ All Day ❑ _____

Pain Type: ❑ Dull ❑ Throbbing ❑ Sharp ❑ Grabbing ❑ Shooting ❑ Burning ❑ Stiffness ❑ Numbness ❑ Tingling ❑ Spasm

Mid Back Pain 0 1 2 3 4 5 6 7 8 9 10

Since onset, pain is: ❑ Better ❑ Worse ❑ Unchanged

Occurs: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Lasts: ❑ Minutes ❑ Few Hours ❑ All Day ❑ _____

Pain Type: ❑ Dull ❑ Throbbing ❑ Sharp ❑ Grabbing ❑ Shooting ❑ Burning ❑ Stiffness ❑ Numbness ❑ Tingling ❑ Spasm

Low Back-Hip-Leg-Foot Pain 0 1 2 3 4 5 6 7 8 9 10

Since onset, pain is: ❑ Better ❑ Worse ❑ Unchanged

Occurs: ❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

Lasts: ❑ Minutes ❑ Few Hours ❑ All Day ❑ _____

Pain Type: ❑ Dull ❑ Throbbing ❑ Sharp ❑ Grabbing ❑ Shooting ❑ Burning ❑ Stiffness ❑ Numbness ❑ Tingling ❑ Spasm

Condition interferes with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation ❑ _____

Makes pain worse to: ❑ Sit ❑ Stand ❑ Walk ❑ Bend ❑ Lie Down ❑ Twist ❑ Rise from seat ❑ _____ ❑ N/A

Makes pain better to: ❑ Sit ❑ Stand ❑ Lie Down ❑ _____ ❑ N/A

Previous treatment received for this condition: ❑ None ❑ Chiropractic ❑ Physical Therapy ❑ Medications ❑ Surgery

Doctor/Practitioner's Name_____ Date of Last Visit ____/____/____

Results of prior treatment: _____

FAMILY HISTORY

Indicate ☑ any family history of the following conditions:

	Back Problems	Cancer	Heart Attack/Disease	Diabetes	Stroke	Arthritis
Mother	❑	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑	❑
Brother(s)	❑	❑	❑	❑	❑	❑
Sister(s)	❑	❑	❑	❑	❑	❑

Dr./Staff Notes

PAST AND PRESENT MEDICAL HISTORY

Indicate ☑ if you now have (within the past 6 months) or if you have ever had these conditions in the past.

NOW	PAST		NOW	PAST		NOW	PAST	
❑	❑	Alcohol/Drug Abuse	❑	❑	Diabetes	❑	❑	Migraines
❑	❑	Anxiety	❑	❑	Fibromyalgia	❑	❑	Neck Pain
❑	❑	Arm Pain	❑	❑	Heart Disease/Attack	❑	❑	Osteoporosis
❑	❑	Arthritis	❑	❑	Hepatitis	❑	❑	Pacemaker
❑	❑	Artificial Bones or Joints	❑	❑	Hernia	❑	❑	Seizures
❑	❑	Asthma	❑	❑	High Blood Pressure	❑	❑	Severe/Frequent Headaches
❑	❑	Back Pain	❑	❑	HIV Positive/AIDS	❑	❑	Shoulder Pain
❑	❑	Bleeding Disorder	❑	❑	Implants	❑	❑	Sinus Problems
❑	❑	Bursitis	❑	❑	Leg Pain	❑	❑	Stroke
❑	❑	Cancer	❑	❑	Mental Disorder	❑	❑	Ulcer/Colitis

Women: Last period ____/____/____ Pregnant ❑ No ❑ Yes…Due Date ____/___/____ Birth Control Pills ❑ Yes ❑ No Menopause ❑ Yes ❑ No

List other **serious or chronic conditions:**_____ ❑ None

List **broken bones, fractures**, or **dislocations**:_____ ❑ None

List past **injuries**:_____ ❑ None

List **surgeries**:_____ ❑ None

_____

Are you presently taking any **medication** - prescription or over the counter? ❑ No ❑ Yes…List:_____

_____

List any **allergies**:_____ ❑ None

Dr./Staff Notes

HEALTH HABITS

Smoking: ❑ Never ❑ Quit or, indicate packs per day _____

Alcohol: ❑ Never ❑ Quit or, indicate drinks per week _____

Caffeinated Beverages: ❑ None or, indicate cups/cans per day _____

Exercise: ❑ Never or, indicate times per week _____ & type of exercise _____

Vitamins/Nutritional Supplements: ❑ None or, list type & dosage _____

Describe your level of stress: ❑ None ❑ Minimal ❑ Moderate ❑ Extreme

Dr./Staff Notes

AGREEMENT AND AUTHORIZATION FOR TREATMENT

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I also agree that I am responsible for all bills incurred at this office.

I understand the above and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient/Guardian Signature_____ Date_____/_____/_____

We invite you to discuss with us any questions regarding our services.
The best health services are based on a friendly, mutual understanding between provider and patient.