

NATURAL HEALTH CENTER, P. C.

8001 Chicago Street ☐ Omaha, Nebraska 68114 ☐ (402) 399-2020

Personal Information:

Confidential Patient Questionnaire

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Age _____ Male _____ Female _____ DOB _____ Phone (Home) _____ Phone (Cell) _____
Phone (Work) _____ Email Address _____
Marital Status M S D W SS # _____ Drivers Lic. _____
Occupation _____ Job Description _____
Employer Name & Address _____
Name of Spouse _____ Employer of Spouse _____ Phone _____
Spouse's SS # _____ DOB _____ Name of Nearest Relative _____ Phone # _____
Name of party responsible for payment _____ Relationship to Patient _____
Social Security # _____ Phone # _____ Referred By: _____

Current complaint: _____

Are your symptoms a result of an accident? Yes ___ No ___ Date of Accident: _____

Date symptoms appeared: _____ Is this condition work related: Yes ___ No ___

At the time of this current complaint, were you under any medically prescribed disabilities or self imposed restriction? Yes ___ No ___

If yes, describe: _____

List any other doctors seen for this condition (include address):

Dr. Name _____ Address _____ Phone _____

Dr. Name _____ Address _____ Phone _____

Did you go to the hospital? Yes ___ No ___ - If yes, how did you get to hospital? Ambulance Other _____

If admitted to hospital, how long did you stay? _____

What type of treatment did you receive? (Include recommendation, x-ray etc..) _____

Any medication prescribed? Yes ___ No ___ - If yes, list name _____

Have you ever received prior chiropractic care? Yes ___ No ___ - Name of Doctor: _____

General Health History: (Check if you have experienced any of the listed items below):

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Tingling | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Concussion | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Sinus History | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Venereal Disease | | | |

If you have indicated **YES** for allergies, please list: _____

If female, are you pregnant? No Yes Date of last menstrual period: _____

Any prior hospitalization or surgery?(list) _____

Health Questionnaire:

Please indicate for each of the following questions below your experience by use of the following codes:

1-Currently have or 2-Previously had (leave blank if not indicated)

Musculo-skeletal

- Neck Pain
- Neck motion restricted
- Heavy feeling of head
- Mid back pain/stiff
- Low back pain/stiff
- Upper back pain
- Rt/Lt. arm pain
- Rt/Lt shoulder pain
- Rt/Lt hip pain
- Rt/Lt leg pain
- Jaw pain
- Rib pain
- Broken bones
- Bruises
- Swollen joints
- Painful joints
- Sore muscles
- Weak muscles
- Walking problems

Radiation of Pain Into – Check:

- Rt. Arm Lt. Arm Both
- Rt. Leg Lt. Leg Both
- Rt. Shoulder Lt. Shoulder

Aggravation of Pain Upon – Check:

- Walking Sitting Standing
- Bending Riding
- Sitting to standing Lying down

Female

- Vaginal discharge
- Vaginal bleeding
- Menstrual symptoms
- Breast pain
- Breast lumps
- Varicose veins
- PMS
- Menopausal symptom

Genito-urinary

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

Gastro-intestinal

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Liver trouble
- Gall bladder problems
- Weight problems
- Hemorrhoids
- Indigestion

Nervous System

- Insomnia
- Fainting
- Loss of feeling
- Paralysis
- Dizziness
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Irritability
- Confusion
- Depression
- Fatigue
- Pins/needles-where?
- _____
- Numbness-where?
- _____

Cardio-vascular/respiratory

- Chest Pain
- Pain over heart
- Deep breathing problem
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problem
- Heart problems
- Lung problems
- Bruise easily
- Cold hands/feet

Eye, Ear, Nose, Throat

- Eye strain
- Eye inflammation
- Vision Problems
- Loss of concentration
- Eye light sensitivity
- Ear Pain
- Ear discharge
- Ear ringing
- Hearing loss
- Breathing thru nose
- Nose pain
- Nose bleeding
- Nose discharge
- Sinus problems
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Horseness
- Difficult speech
- Loss of taste
- Loss of smell

Habits:

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

Do you have a pacemaker? - Yes No

Do you now take vitamins? - Yes No

Do you now take minerals? - Yes No

Do you think you may need to take

Vitamins/Minerals Yes No

Are you wearing:

Heel Lifts Sole Lifts

Inner Soles Arch Supports

Pre-Existing Conditions:

Have you sought care for any other health condition within the last year? Yes No Past 2 years? Yes No

If yes, what condition? _____

Was treatment administered? No Yes – if yes, describe: _____

Are you on prescription medications on a regular basis? No Yes – if yes, describe: _____

PATIENT – DOCTOR – AGREEMENT

The purpose of this agreement is to allow us to better serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

SIGNING IN

Please arrive prior to your scheduled appointment & sign in at the front desk. You will be called and assigned a treatment room in the order you signed in for your appointment.

MISSING OR CHANGING APPONTMENTS

We will set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for you to get the results we both desire. If you need to change the time of your appointment, call and arrange another time the same day. If the same day is not possible, be sure to make up the missed appointment within one (1) week.

PAYMENT DUE AT TIME OF SERVICES

*All services & products are payable on the day of the service unless special arrangements have been made and approved by the Doctor and Patient Accounts Manager. **All nutritional products, orthopedic supports, spinal and leg pillows, as well as foot orthotics are taxable items that must be paid the same day that the order is placed.***

ALL PRODUCTS ARE NON-REFUNDABLE DUE TO FEDERAL HEALTH AND SAFETY STANDARDS.

MAJOR MEDICAL GROUP HEALTH INSURANCE

This clinic is not a participating provider with any insurance carrier. Your insurance is an agreement between you and your insurance company, not between your insurance company and our clinic. It is understood and agreed that services rendered are charged to you directly and payment is expected at the time of service. Our Office will provide you with a superbill to mail in with a claim form from your insurance company

It is imperative that you understand the following conditions and agree to them:

1. You are required to sign the informed consent agreement, financial agreement, and medical records release forms as well as any other assignment documents required by your insurance company and our office.
2. If you are to be reimbursed by your insurance carrier it will likely be within 30 days of your office visit. If your insurance has not paid or you have not received an explanation of benefits within 30 days, please contact our office and we will place a call to your insurance company for you.
3. You are required to pay for all services provided to you at each visit. Any past due accounts are subject to a 20% annual fee.
4. Our office will not enter into a dispute with your insurance company over any claim. This is ultimately your responsibility and obligation.
5. **Our office cannot guarantee that your insurance company will pay.**
6. The doctor and patient and/or their representatives in advance of care must sign any special arrangements regarding finances.

AUTO ACCIDENTS

Patients involved in auto accidents may receive 100% coverage for conservative treatment under the Medical Payments portions of their auto policy. This does not include any nutritional and/or other taxable products. Auto accident coverage usually comes with a dollar limit and possibly a time limit. No services will be rendered without the appropriate claim information first. *****We are under no obligation to accept any insurance company's reduction of our fees which are reasonable and customary for our area.** If an

attorney has sent you to our office we will need the attorney's name, address, phone number and all other relevant information prior to your first visit. Should you miss or cancel more than three appointments we will release you from our care due to non-compliance. If an attorney is not representing you, we will ask for your group health insurance information. Once your medical payments limits have been exhausted on your auto policy and you are still actively under our care, we will then file claims with your health insurance carrier with the exception of BlueCross BlueShield (see Major Medical Group Health Insurance section). You, the patient, are responsible for the bill, but may not be personally required to pay at the time of service (except for nutritionals or other taxable items) as long as: 1). We are billing your insurance company, 2). You and your attorney have signed the necessary lien forms, and 3). We have all necessary claim information. This will insure that the clinic will be paid at the time of settlement of your case.

WORKER'S COMPENSATION

We **DO NOT** take any worker's compensation cases unless specifically approved by the Doctor. Worker's compensation patients may receive 100% coverage for all examination, treatment and X-ray costs once treatment has been authorized. All claim information and treatment authorization must be provided by the second visit. This approval must be in writing by the insurance carrier prior to starting an active treatment program. **Note Auto & Worker's Compensation Patients:** If you choose to discontinue or dismiss yourself from care without the doctor's authorization the balance of your account is due and payable in full at the time of your discontinuance even if your insurance has been filed.

MEDICAID

This clinic accepts traditional Medicaid and Primary Care Plus. You will be asked to present your current Medicaid Card to the receptionist each month. Our office will submit the forms necessary for reimbursement of your chiropractic care, which allow for 18 visits in 3 months and only one (1) visit per month thereafter. Medicaid will only pay for spinal manipulation. All addition visits or services are to be paid for by the patient at the time of service. You are responsible for all co-pays at the time of visit.

MEDICARE

Manipulation of the spine is limited to a diagnosis that shows "a significant health problem in the form of a neuromusculoskeletal condition necessitating treatments." These treatments have a specific time limit according to the four categories (acute, exacerbation, recurrence, and chronic) that Medicare covers. **Medicare does not pay for nutritional products, orthopedic shoes or inserts, pillows or leg supports, acupuncture or therapy.**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. A photocopy of this authorization shall be as valid as the original.

I have read over the financial policy for this office and accept these terms. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions. I understand interest will be charged at a rate of a minimum of \$2.00 or 1.5% per month (18 APR) on balances over 30 days and that I am liable for all legal and collection fees.

Patient or Guarantor Signature _____ Date _____
