

PATIENT APPLICATION FORM
WELCOME TO BANIC CHIROPRACTIC CLINIC

Patient Name: _____ Date: _____
Address: _____ Apt. #: _____
City _____ State: _____ ZIP: _____ eMail: _____
Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____
Best Way to Reach You: Home ☐ Work ☐ Cell ☐ eMail: ☐
Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____ M F
Occupation: _____ Employer: _____
Employer Address: _____
Marital Status: Single Married Number of Children: _____ Ages: _____
Spouse's Name: _____ SSN#: _____ - _____ - _____ DOB: _____
Address: _____ Phone: _____
Emergency Contact: _____ **Phone:** _____

Where did you learn about our office & may we contact them? _____
What is your chief complaint today? _____
Have you received Chiropractic Care in the past? Y N When? _____
Please describe the reason for previous care: _____
Name of previous Chiropractor(s): _____
Name of Primary Care Practitioner(s): _____

Name of Insured: _____ Relationship: _____
Primary Health Insurance: _____ Policy #: _____
Primary Health Insurance Phone # (located on back of card): _____
Secondary Health Insurance: _____ Policy #: _____
Secondary Health Insurance Phone # (located on back of card): _____
Is this visit a result of: Personal Injury Auto Accident Workers Compensation
Attorney Name and Phone # (if applicable): _____

What is your major complaint? _____

When did you first notice this complaint? _____

What event(s) brought it on? _____

What activities aggravate the condition? _____

Are you pregnant? Yes ____ No ____ If yes, how many months? _____

MEDICAL BACKGROUND:	
Please list any/all illnesses	
Please list any/all medications:	
Please list any/all allergies:	
Please list any/all musculoskeletal problems:	
Please list any/all accidents and dates:	
Please list any/all surgeries and dates:	
Please list regular activities and/or repetitive movements:	
Are you experiencing any pain, numbness, stiffness, or swelling? If yes, please explain:	

Because massage therapy should not be performed under certain medical conditions it is important that the therapist be informed of any medical conditions the clients has. Please affirm that you have provided all medical conditions. ____ (initial)

Please affirm that you understand that manual therapy is not a substitute for medical diagnosis and treatment. ____ (initial)

Signature _____ Date _____

ASSIGNMENT AND RELEASE

I authorize release of my health care information to other healthcare practitioners.
I authorize release of my health care information to insurance companies.
I authorize the taking of photographs and X-rays to be used for diagnostic purposes.
I authorize the performance of other diagnostic and therapeutic procedures.
I authorize my insurance benefits to be paid directly to: Banic Chiropractic Clinic.

Patient's Signature: _____ Date: _____

PAYMENT POLICIES

1. PAYMENT OF YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR FIRST OFFICE VISIT.
 2. At the completion of your first office visit, you will be advised to return for a second visit at which time the doctor will provide you with information regarding your examination results and your treatment plans if your case is accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.
 3. Although we verify insurance coverage as accurately as possible, the INSURANCE COMPANIES DO NOT GUARANTEE ANY PAYMENTS, therefore you are financially responsible for any denied payments and/or remaining balance. We **STRONGLY** recommend that you call your insurance carrier and verify benefit specifics.
 4. All massage appointments require 24 hours' notice for cancellation or any schedule changes. There is a 40.00 fee for no-shows or cancellations. Such penalties are not covered by insurance and are your responsibility.
- I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

HIPPA (HEALTH INSURANCE PORTABILITY AND PRIVACY ACT)

Drs. Banic and staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If you are not available, a message may be left on your answering machine or with a family member.

We offer spinal adjustments and other therapeutic procedures in an open-adjusting room style, with other patients in the same room. Occasionally comments about your symptoms, improvements, or lack thereof may be discussed during your office visits. You may request a private adjustment at any time with no need for explanation.

We perform online insurance billing services through an insurance clearinghouse. All your healthcare information is protected in this process by HIPAA. We have invested in current virus protection and removable and locking hard drives to further protect your health information.

You have the right to refuse us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization by mailing a request to our clinic at any time. We will not be able to honor your request if your health information has already been released and it may not extend to information required by your insurance company to settle your claims.

I authorize Banic Chiropractic Clinic to use or disclose my health information in the manner described above. I also understand that I may request a copy of this form.

Patient's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

HIPAA, the Health Insurance Portability and Accountability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

THIS PACKET DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.

Please Read and Review it Carefully

If you have any questions about this notice, please contact our office. We appreciate the trust that patients place in us and we recognize the importance of protecting the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. When conducting transactions with patient designated health carriers or affiliates, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians and all other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status and the healthcare/services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent. You must signify your understanding and agreement by signing and dating this cover sheet for our records. You may opt out of this agreement at any time by presenting this office with written notice of your wishes.

Patient or Guardian Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Massage Cancellation Policy

Massage times are reserved specifically for you. Because of this we require your credit card on file to hold your appointment. Any changes or cancellation of your appointment requires a 24 hour notice to us by phone or email. There is a \$40 fee for no-shows or cancellations and a \$15 fee for late arrival (14 minutes or more). Such penalties are not covered by insurance and are your responsibility and will be charged to the credit card on file.

Patient Signature: _____ Date: _____