Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐Y ☐N If so, how far along? _____ Nursing? ☐Y ☐N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

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

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Iliff Chiropractic
Dr. Daniel A. Iliff
Acknowledgement of Receipt of Privacy Policy

I acknowledge Iliff Chiropractic, the office of Dr. Daniel A. Iliff, "Notice of Privacy" has been provided to me. I understand that I have the right to review Dr. Iliff's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Iliff Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Iliff Chiropractic is also provided on request at the main desk of the practice.

Iliff Chiropractic, the office of Dr. Daniel A. Iliff, reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised "Notice of Privacy Practices" by calling the office and requesting a revised copy be sent to me in the mail or for asking for one at the time of my next appointment.

_____ _____

(Signature of patient or personal representative) date

_____

(Printed name of patient or personal representative)

_____

(Description of personal representative's authority)

Iliff Chiropractic

2560 S. Cleveland Ave. Suite 4
Saint Joseph, MI 49085
Financial Policy

Iliff Chiropractic is committed to providing you with the best possible chiropractic care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for our professional services.

- Our office contracts with a variety of insurance plans. If you are a member of one of these plans, our billing
department will submit a claim for our services.

It is your responsibility to:

Provide all current insurance information and present your insurance card at each visit.
Pay your full co-pay at each visit.
Pay any balance not covered by your plan including any deductibles, co-pays and non-covered services.
Know your own insurance benefits.

- If you have insurance for which we are not a contracted provider, we will bill the insurance as a courtesy. Payment in full is expected at the time of service.
- Patients with patient pay balances will receive a monthly statement. The statement will indicate separately your balance and what is still pending from insurance. Payment of your outstanding, balance is required within 30 days of receipt of the statement. Patient balances greater than 30 days will be referred to collection.
- Authorizations: It is your responsibility to ensure that any required authorizations for treatment are provided to the practice prior to the visit. If you do not have authorization, your visit may be rescheduled, or you may be financially responsible.
- If the patient is a minor (~17 years or younger), the parent or guardian must sign below. -
- Some services may not be a covered service by your insurance plan. It is your responsibility to pay any balance not covered.
- If you have any questions about your insurance coverage or limits, please direct those to the member services department at your insurance company. The number is usually on your card. For other questions or concerns about your account with us, please call our office at *269-983-1800.*
- A charge of $25 will be assessed for all returned checks.
- If you arrive late for your appointment, you may be asked to reschedule.
- Our No Show Policy states that failure to show up for an appointment, and any cancellation that occurs less than 24 hours prior to your appointment will result in a $25.00 charge. After three occurrences, the practice may elect to terminate your relationship with us.

We strongly believe that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to our billing department.

Assignment

I authorize release to any third party payers such as an insurance company or governmental agency, any medical information contained in my records when such material is required in connection with determining a claim for payment. I herby assign all payments for medical services for myself and/or dependent to Iliff Chiropractic; I agree to pay for any charges not covered by my insurance plan.

Please print responsible party name _____ Patients name _____

Signature of responsible party _____ Date _____