PATIENT REGISTRATION

Effective Jan.1, 2013 all health care clinics are required to have the following information on file. Please complete all sections.

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Gender:** Male Female Other **Weight:** _____ **Height:** _____

Marital Status: Single Married Other **Preferred Language:** English Other: _____

Do You Smoke: Current Former Never **Frequency:** (per day) 1-5 1/2 Pack 1 Pack 2+ Packs

Race: Asian African American White Other: _____

Ethnicity: Decline to Disclose Non-Hispanic Hispanic Puerto Rican Unknown

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Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

We now offer phone, text or email reminders, please circle which method you prefer: Call Text Email

Please let us know how you found out about our Clinic: _____

Employment: Full Time Part Time Student Unemployed Retired Other: _____

Company Name: _____

Job Title: _____

Work Phone: _____ **Ext:** _____

☐ Please check this box if you *do not* want to be contacted at work.

Emergency Contact: _____

(Must be a family member or someone able to make medical decisions on your behalf in the event of a medical emergency.)

Relationship to Patient: _____

Cell Phone: _____ **Home Phone:** _____

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

Gender: M F O **Marital Status:** S P M D W **# Children:** _____

Please circle your current health condition: Critical Poor Average Good Great

Medical / Surgical History

Please circle any current or previously diagnosed medical conditions:

Alcoholism	Glaucoma	Osteoporosis
Allergies	Heart Disease	Pregnancy
Anemia	Headaches/Migraines	Psychological
Arthritis	Hepatitis/Liver Disease	Reproductive
Asthma/Emphysema	High Blood Pressure	Respiratory
Broken Bones	High Cholesterol	Seizures
Cancer _____	Hormone Imbalance	Skin Condition _____
Cardiovascular _____	Immune System _____	Stress
Cataracts	Inflammation	Stroke/TIA
Depression	Low Blood Pressure	Swelling
Diabetes	Menstrual	Thyroid Disorder
Dietary Problems	Muscular _____	Urinary
Endocrine/Glands _____	Nervous System _____	Varicose Veins
Fibromyalgia	Numbness/Tingling	Other _____

Do you have any communicable diseases? _____

Please circle any allergies and describe their associated reactions:

Food _____ Latex _____ Medications _____

Animals _____ Plants _____ Other _____

Please list any past surgeries/dates:

_____

_____

Please list any vitamins/supplements/herbs:

_____

_____

Please list all prescription medications you are currently taking and their doses: _____

_____

Office Use Only: Provider signature for ND/LMT/LAc: _____

Patient Name: _____ **Date of Birth:** _____

Please circle if you have experienced any of the following during the past year:

Personal Illness or Injury	Major Illness or Death in Family	Death of a Close Friend
Change of Residence	Loss of a Job	Divorce or Separation
Retirement	Loss of a Pet	Marriage

Family Health History

Please circle the condition a family member has and indicate the relationship:

Diabetes _____	Cancer _____	High Blood Pressure _____
Depression _____	Suicide _____	High Cholesterol _____
Heart Attack _____	Stroke _____	Alcoholism _____
Thyroid Disease _____	Other _____	

Current Health History

Please circle any conditions you currently have or had in the past:

Vision or Eye Changes	Autoimmune Condition	Loss of Libido
Trouble Swallowing or Heartburn	Back, Joint or Muscle Pain	Problems with your Feet
Lost or Gained 10 Pounds Recently	Difficulty Urinating/Holding Urine	Swelling of Ankles/Feet
Shortness of Breath/Coughing Fits	Frequent or Intermittent Dizziness	Difficulty Sleeping
Chest Pain or Heaviness with Activity	Severe Headaches/Migraines	Suffered Any Recent Falls
Recent Change in Bowel Movements	Tire Easily or Exhaustion	Hearing or Ear Conditions

For Women Only: Abnormal Vaginal or Menstrual Bleeding Taking Birth Control or Estrogen

For Men and Women: Breast Lumps or Nipple Discharge Do a Monthly Breast Exam

Do you eat a special diet?	Yes	No	Description: _____
Do you exercise regularly?	Yes	No	How often: _____
Do you chew tobacco?	Yes	No	How often: _____
Do you drink alcohol?	Yes	No	How much: _____
Do you drink caffeine?	Yes	No	How much: _____

(Caffeine is in soda, energy drinks, tea, coffee, and many other products.)

Patient Name: _____ **Date of Birth:** _____

Please answer the following questions regarding your appointment today:

Is today's visit due to a major vehicle crash? Yes No

Is today's visit due to an on the job injury? Yes No

Have you ever been to a chiropractor before? Yes No

If yes, when? _____ What for? _____

Have you had recent x-rays taken? Yes No

If yes, when? _____ Where? _____

What areas were imaged? _____

Your Primary Physician: _____ Your Last Physical Exam: _____

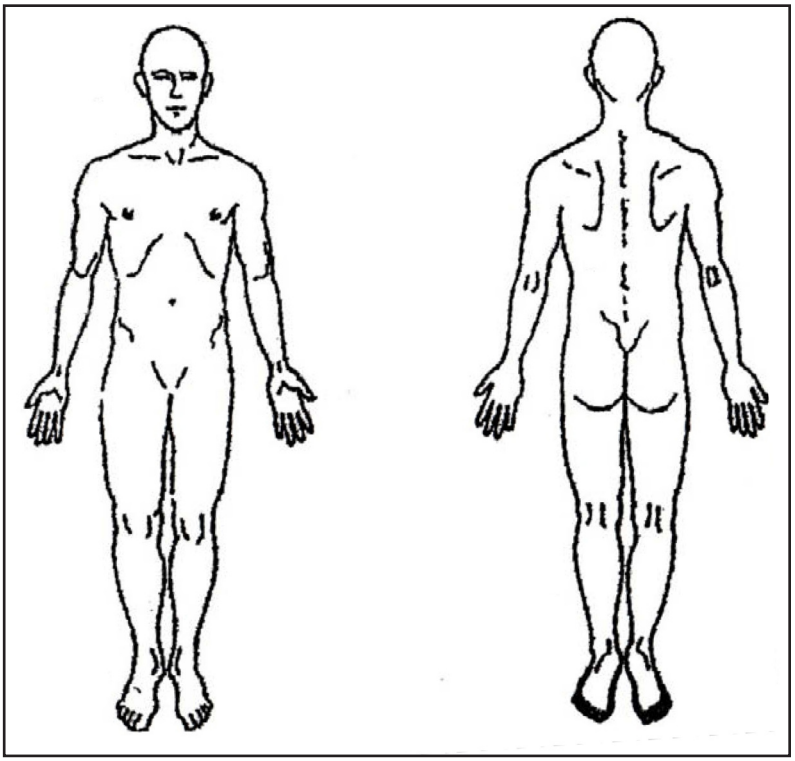
Do you wear? Heel Lifts Inner Soles Arch Supports Negative Heels Platforms

Date your current symptoms appeared: _____

Indicate Where You Are Hurt

Indicate using the symbol key the areas of your body where you are feeling symptoms. If you are experiencing pain that radiates, please use an arrow to indicate where it begins and ends.

Ache	Numbness	Pins & Needles
<<<<<	·····	**ooooo**
Burning	Stabbing	Throbbing
xxxxx	/////	~~~~~



1. What is your symptom intensity right now?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

2. What is your typical or average symptom?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

3. What is your symptom intensity at its worst?
0 1 2 3 4 5 6 7 8 9 10
None *Unbearable*

4. How often are your symptoms present?
0 - 25% 26 - 50% 51 - 75% 76 - 100%

5. How much do your symptoms interfere with your daily activities?
0 1 2 3 4 5 6 7 8 9 10
None *Unable to Perform*

Doctor's Initials _____ Date _____

OFFICE FINANCIAL POLICY

Thank you for choosing Blyss Chiropractic as your Chiropractic provider. Blyss Chiropractic and our independent contractors are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan are contracted with, payment in full is expected at each visit. If you are insured by a plan which we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Time of Service Discount**. We offer a time of service discount to our patients who have high deductibles, no health insurance, or simply prefer to self-pay. Payment is due in full at the time services are rendered. Please note that we will not bill your insurance or go back and bill at a later date once a Time of Service discount is given.

3. **Co-Payments and Deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us to uphold the law by paying your co-payment at each visit.

4. **Non-Covered Services**. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of each visit.

5. **Proof of Insurance**. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your current photo ID and your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full balance of the claim.

6. **Claims Submission**. We will submit your claims and assist you in any way that we are reasonably able to do in order to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

OFFICE FINANCIAL POLICY

7. **Coverage Charges**. If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

8. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will be available to treat you on an emergency basis, and will follow up with any new providers regarding your treatments, should you request this.

9. **Appointments.** Our policy charges a $50 deposit for all new patients and for the second missed appointment not canceled within a 24 hour time period prior to your scheduled appointment time. These charges will be your responsibility and will be collected upon scheduling or billed to you directly. Please help us to serve you and our other patients by keeping your regularly scheduled appointments and canceling or rescheduling in a timely manner when necessary. Independent Contractors may have differing charges for missed appointments.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Patient/Guardian Signature Date

RISK AND CONSENT FOR TREATMENT

Chiropractic examination and therapeutic treatment procedures (including spinal adjustments, ultrasound, heat/cold application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. **Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms.** Instrument assisted soft tissue mobilization can be associated with short-term bruising as part of the normal therapeutic process, but usually accompanies improved function. More serious complications are rare and their association with spinal adjustments/manipulation is debated. The patient's best interest combined with known facts will be considered for best judgement regarding these risks. Additional information on the possible side-effects, complications, and effectiveness of spinal adjustments is available upon request. For proper perspective, the risks of chiropractic and neck treatment should be compared to the risks of other treatments for similar conditions.

CONSENT TO AUTHORIZE DISCLOSURE OF INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Insurance ID/Account No: _____

I hereby authorize the use and disclosure of individually-identifiable health information relating to me as described below:

Specific description of information to be used or disclosed:

a) Schedule, re-schedule, confirm or cancel appointments.
b) All account financial information, to include all third party information. Examples include making payments, insurance inquiry, account balances or collection inquiry.
c) Requesting medical records and billing invoices.
d) Retrieving prescriptions, imaging orders, medication samples, or specific written doctor's orders.

I authorize the following person(s) to receive my information: _____

_____

_____

I understand I may revoke this authorization at any time by notifying Blyss Chiropractic in writing. If I chose to do so my revocation will not affect any actions taken by Blyss Chiropractic before receiving my revocation.

This Authorization Will Expire on:12/31/25 (unless revoked sooner by patient/representative)

Patient Signature: _____ **Date**: _____

Patient Representative:

Name: _____ Relationship to Patient: _____

Driver License Number: _____ Issuing State: _____

Signature: _____

SIGNATURES FOR OFFICE POLICIES

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, artificial joint(s), etc.), I should discuss this with the practitioner providing me care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Blyss Chiropractic and our independent contractors reserve the right to terminate a practitioner/patient relationship if a patient is continually unable to comply with a reasonable treatment plan by repeatedly missing scheduled appointments, or if inappropriate behaviors are directed at others within the clinic.

_____ Cancellation and Bounced Check Policy: I understand that there is a $50 charge for missing appointments beyond 3 that have not had 24-hour advanced notice for cancellation. I also understand that there is an additional $40 charge for all returned checks (non-sufficient funds).

_____ Occasionally, this clinic participates in internships/observation opportunities for chiropractic students. This intern or student may be present in the treatment room during your office visit. You may request privacy at any time or chose NOT to participate by leaving this space blank.

PATIENT ACKNOWLEDGMENT OF RISK AND CONSENT TO TREAT

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided to me within this medical office. I have read and understand the statements regarding risks, treatments, and the possible complications thereof and understand that there is no guarantee or warranty for a specific cure or result.

Patient Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF PRIVACY POLICY

By signing this document, I acknowledge that the information has been provided to me and applies to any treatment that is provided to me within this medical office by associates and/or independent contractors.

Patient Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF OFFICE POLICY AND FINANCIAL AGREEMENT

By signing this document, I acknowledge that the information has been provided to me and applies to any treatment that is provided to me within this medical office, including those rendered by independent contractors. I further acknowledge that based on this information, I am fully responsible for the payment of the services provided and authorize my insurance benefits to be paid directly to Blyss Chiropractic. I understand and agree to all of the said applicable responsibilities, policies, and risks.

Patient Signature: _____ Date: _____

HEALTH INSURANCE VERIFICATION FORM

All TO BE FILLED OUT BY PATIENT –Esp. HIGHLIGHTED AREAS

☐ Checked Benefits Online

Phone #: _____ Reference / Rep.: _____

☐ New Patient ☐ Primary

☐ Related to Motor Vehicle Crash ☐ Secondary

Name as it appears on insurance card: _____ DOB: _____ ☐ Self

Subscriber (if different from above): _____ DOB: _____

☐ Spouse ☐ Child ☐ Other:_____

Ins. Provider: _____ ID # (include any letters) _____

Group Name: _____ Group # _____

Active: Y ☐ N ☐ Effective Date: _____

☐ Calendar Year ☐ Plan Year Deductible: $ _____ Remaining: $ _____

Chiropractic

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____% Custom Orthototics Covered Y N

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Physical Therapy

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Naturopathy

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Massage

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy