Lucas Chiropractic Clinic
1261 S. Seward Meridian Parkway. Suite F.
Wasilla, Alaska 99654

Today's Date: _____ Injury or Onset Date: _____

Reason for your visit today:

_____

_____

_____

Personal Information

Patient Name: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Gender: Male / Female **S.S.N. (required for insurance submittal) _____**

Current Mailing Address: _____

Phone Number: Home: _____ Cell: _____ Work: _____ Preferred number? _____

Email Address: _____

Employment and Emergency Contact Information

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Who referred you to our clinic? _____

Release of Information

Please list any person who you wish to grant access to your personal/billing information:

_____ Initial: _____

Payment Information

Who will be responsible for this bill? Name: _____ Relationship to Patient: _____

Account type: □ Self Pay □ Primary Insurance □ Workman's Compensation □Auto Insurance □ Other: _____

Primary Insurance Company: _____ ID #: _____ Group: _____

Secondary Insurance Company: _____ ID #: _____ Group: _____

Your Relationship to the Insured: _____

Treatment Consent

I give my consent for examination and the performance of any tests or procedures required. I understand that I will be notified of my financial obligation before any additional testing/treatment is performed. I verify that the above provided information is correct and complete to the best of my knowledge.

Signature: _____ Date: _____

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Financial Policy:

It is important that patients understand that they are responsible for any charges incurred for care at Lucas Chiropractic Clinic. Payment is due at each service date, if payment is not able to be made in full the patient may refer to our payment plan guidelines. If insurance coverage is involved the patient will be responsible for any non-covered charges. If a patient is unsure what their insurance covers, they may contact their insurance directly and ask for specific benefit information. A patient may also request that we contact their insurance to verify their coverage with our clinic. *Please note that an insurance verification performed by a staff member of Lucas Chiropractic Clinic is not a guarantee of benefits and may be subject to change based on the insurance companies discretion and the patients contract with their carrier.*

If a patient is unsure of their insurance coverage we will collect 50% of their total charges at the time of service until charges are processed by their insurance company and any credit that may occur as a result of overpayment will be returned to the patient after insurance has processed.

Initial: _____

Service Pricing:

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. Patients may be entitled to a network or contractual discount under the following circumstances:
    a. We are a participating provider with your health plan
    b. You are covered by a State or Federal program with a mandated fee schedule.
    c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers patients and their dependents. Ask our staff for more information.
    d. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time based on verification and eligibility.
    e. You are a non-insured or underinsured person with valid military ID.

Initial: _____

Payment Plans:

Our clinic offers payment plans to established patients with balances over $100.00. In order to qualify for a payment plan, a valid credit card must be provided on a signed payment plan agreement. Payments will be deducted in accordance with the completed Credit Card Payment Authorization Form. All payment plan agreements must be approved by our billing department. It is the responsibility of our patient to notify us of any changes in regards to their credit card, if a patient has not contacted us by the scheduled payment date resulting in declined payment, the account may be sent to collections with Cornerstone Credit Services immediately and a 30% administration fee will be applied to cover collection expenses.

Initial: _____

Past Due Accounts:

We expect that all balances incurred by our patients will be resolved within 90 days; we will make all reasonable attempts to resolve these debts in a fair and timely manner. Delinquent accounts (any account with a balance due past 90 days) may be charged a 30% administrative fee on top of the current balance and forward to Cornerstone Collections services for collection of debt.

Initial: _____

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Massage Cancellation Policy:

Due to the scheduling demands of our therapists and clinic, we require a 24-notice of cancellation on all scheduled massages. If the appointment occurs on a Monday cancellation may be made with 24-hour notice by leaving a voicemail for our staff. *If a patient fails to notify us within 24-hours of their scheduled appointment time they will be subject to a charge of $30.00 per scheduled half hour. In addition any patient who arrives late for their appointment will be billed for the entirety of their scheduled time regardless of the length of time the therapy is able to be performed.*

Please note that this fee cannot be forward to the patients insurance company and must be paid by the patient directly.

Initial: _____

Text and E-mail Reminders Release:

As a courtesy to our patients we have the option of sending text and/or email reminders of your scheduled appointments. Please indicate if you would like to receive these reminders and which format you would prefer. Standard messaging rates may apply based on your cell phone providers plan however no additional fee will be charged by our clinic.

Opt In Text Messaging- YES_____ NO_____
Cell Phone Provider: _____

OR

Opt In Email Reminders- YES_____ NO_____

Initial: _____

HIPPA Privacy Practices:

We are required by law to maintain the privacy of confidential patient information and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you would like to review our full HIPPA Privacy Practice packet please see the front desk for a copy. If you have any objections to this form please speak with our HIPPA Compliance officer in person or by phone at (907) 357-6100.

By initialing and signing below, you authorize Lucas Chiropractic Clinic to release medical records required by your insurance company(s). You authorize your insurance company to pay benefits directly to Lucas Chiropractic Clinic. You agree that a reproduced copy of this authorization will be as valid as the original. You understand that by signing below you are giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.

Authorize Release: Initial: _____

By signing below I state that I have read and understand the above listed policies. I have been able to clarify and ask any questions I may have and I hereby agree to abide by all policies listed in this document.

Patient Signature: _____
Printed Name: _____ Date: _____

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Please check any conditions that you have had in the past or are dealing with currently.

Musculoskeletal
□ Arthritis / rheumatism
□ Bursitis
□ Foot trouble
□ Muscle weakness
□ Low back pain
□ Neck pain
□ Mid back pain
□ Joint pain
□ Headaches
□ Gout
□ Osteoporosis

Neurological
□ Depression
□ Dizziness
□ Fainting
□ Fatigue
□ Fever
□ Migraine
□ Loss of sleep
□ Mental illness
□ Nervousness
□ Seizures / Convulsions
□ Tremors
□ Epilepsy
□ Numbness
□ Tingling

Head, Ear, Nose & Throat
□ Colds
□ Deafness
□ Ear ache
□ Eye pain
□ Gum trouble
□ Hoarseness
□ Nasal obstruction
□ Nose bleeds
□ Ringing of the ears
□ Sinus infection
□ Sore throat
□ Tonsillitis
□ Vision problems
□ Emphysema

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Hardening of the Arteries/ Atherosclerosis
□ Pain over heart
□ Palpitation/ Irregular pulse
□ Poor circulation
□ Rapid heart beat
□ Slow heart beat
□ Stroke
□ Heart disease
□ High cholesterol
□ Anemia
□ Edema/Swelling
□ Varicose veins
□ Bruise easily

Gastrointestinal
□ Abdominal pain
□ Bloody or tarry stool
□ Colitis / Crohn's
□ Colon trouble
□ Constipation
□ Diarrhea
□ Gas
□ Diverticulosis
□ Bloated abdomen

Gastrointestinal Cont.
□ Excessive hunger
□ Gallbladder trouble
□ Hernia
□ Hemorrhoids
□ Jaundice
□ Liver trouble
□ Nausea
□ Painful defecation
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Heart burn
□ Ulcers

Respiratory
□ Chest pain
□ Chronic cough
□ Difficulty breathing
□ Shortness of breath
□ Spitting up phlegm/blood
□ Wheezing
□ Bronchitis
□ Asthma

Genitourinary
□ Bed-wetting
□ Bladder infection
□ Kidney infection
□ Kidney stones
□ Prostate trouble
□ Increased frequency of urination
□ Decreased flow/force
□ Painful urination
□ Urgency to urinate
□ Weak Bladder or Incontinence
□ Infertility
□ Hepatitis
□ Herpes
□ Cold sores
□ HIV/AIDS
□ Low Testosterone

Women Only
□ Congested breasts
□ Hot flashes
□ Lumps in breast
□ Menopause
□ Miscarriage

Menstrual flow
□ Reg. □ Irreg.
□ Pain / cramps

Are you pregnant?
□ yes □ no
If yes, how many months? _____
How many children do you have? _____

Endocrine
□ Diabetes
□ Autoimmune
□ Thyroid disease
□ Goiter
□ Multiple sclerosis

Dermatological
□ Dryness
□ Hives or allergies
□ Itching
□ Rash
□ Eczema

Illnesses:
□ Alcoholism
□ Appendicitis
□ Mumps
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Tuberculosis
□ Influenza
□ Malaria
□ Measles
□ Tumors
□ Cancer
□ Chicken pox
□ Boils

General
□ Allergies
□ Weight loss / gain
□ Pace maker

Current Condition

Give a brief detailed description of the problem you are currently experiencing:

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes □ no

Does it affect your (check appropriate box): □ work □ sleep □ other: _____

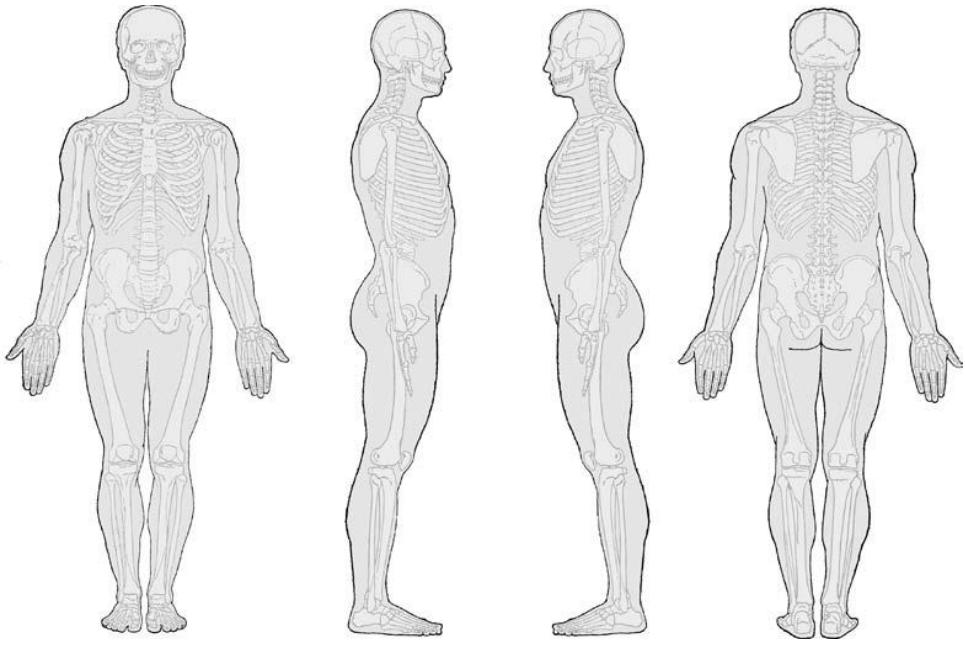
What seemed to be the initial cause: _____

Please mark your area(s) of pain on the figure(s) below

Worst Possible Pain

Please place a mark on the scale of your current pain level:

No pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How would you describe your daily activity level? □ light □ moderate □ heavy

How old is your mattress? _____ is it □ soft □ firm

Do you sleep on your □ back □ side □ stomach?

When was your last physical exam? _____

Habits	never	light	moderate	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty food	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history Please mark any history of your blood related *Grandparents, Parents, Siblings, Children*

□ Alcoholism
□ Arthritis
□ Cancer
□ Epilepsy
□ High blood pressure
□ Osteoporosis
□ Anemia
□ Asthma
□ Diabetes
□ Glaucoma
□ High cholesterol
□ Stroke
□ Arteriosclerosis
□ Bleed easily
□ Emphysema
□ Heart disease
□ Multiple sclerosis
□ Thyroid disease

_____

Patient Signature *Date*