Patient Update Form

Patient Name_____ Date _____

Preferred Name_____

Gender M F Other_____ Date of Birth _____ Age _____

Address_____ City_____ State_____ Zip_____

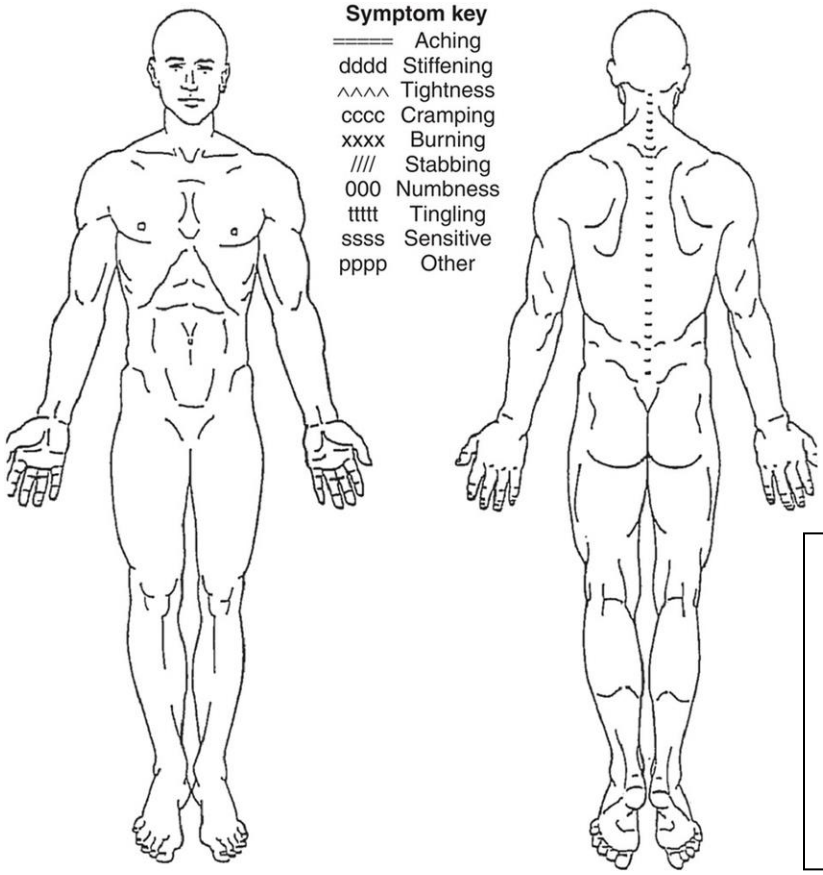
Cell Phone_____ Home Phone_____ Work Phone_____

Email _____ Employer_____

Medical Insurance _____ ID# _____

PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:



Height_____

Weight_____

Blood Pressure_____

Patient Name_____ Date _____

Chief Complaint_____

Complaint began when and how? _____

Grade Intensity/Severity (No complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

Does this pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where?_____

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint _____

Any changes in your health history, such as surgeries, child birth, injuries, etc?

_____

_____

Any changes in your work environment? Describe:

_____

Sitting _____ Standing _____ Walking _____ Lifting _____

Prescription Medications (Please List)

_____

_____

Over the Counter Medications and/or supplements (Please List)

_____

_____

Recreational Activities

__Backpacking	__Biking	__Boating	__Running
__Golfing	__Racquetball	__Tennis	__Rock Climbing
__Skiing	__Soccer	__Swimming	__Walking
__Weight Lifting	__Football	__Basketball	__Volleyball
__Cross Fit	__Dancing	__Yoga	__Other

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for Patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid at time of visit
- Cancellation/No Show policy: 24 hour notice is required for all appointment cancellations. A $15.00 fee will be charged to the patient for all late cancellations and no shows.

Self Pay Patients: When you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

Medical Insurance: As a courtesy to patients, we will bill your primary insurance carrier; however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that payments be made directly to Tracy & Keim Chiropractic, LLC. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan.

Personal Injury/Auto Insurance: Regardless of who the responsible party is, a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurer is withholding payment for any reason, you will be required to start paying for services: we do not hold balances over $800.00 we require that you sign a lien form assigning payment to Tracy and Keim Chiropractic, LLC from an insurance company or from an attorney in cases where one has become necessary.

Worker's Compensation: You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

Medicare: We are non-participating providers but can accept Medicare patients. Medicare only pays toward spinal manipulation related to an incident or injury, and they will send payment to you. You will be required to pay at the time of service for all services or supplies in our office.

Thank you for taking the time to read this policy. If you have any questions, please don't hesitate to ask.

_____ _____

Patient or Guardian Signature Date