



Who can we thank for referring you to us? _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Mid-Initial: _____

Social Sec. No.: _____ - _____ - _____ E-mail address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birthday: ____/____/____ Sex: F M Marital Status: Married Divorced Widowed Single

Home No.:(____) _____ Work No.:(____) _____ Cell: (____) _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone :(____) _____

RESPONSIBLE PARTY:

Name of person responsible for payment: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work No.:(____) _____

INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: _____

Birthday: ____/____/____ Social Sec. No.: _____ - _____ - _____ Date of Employment: ____/____/____

Name of Employer: _____ Work No.:(____) _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Co.: _____ Phone No.:(____) _____

Group No.: _____ Employer No.: _____ Member ID: _____

How much is your deductible? _____ How much have you used? _____ Max Annual Benefit? _____

FAMILY HISTORY

Relationship	Conditions	Alive	Deceased
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____

How much of the following do you take in or participate in each day:

Tobacco ____Packs/day Alcohol ____Drinks/day Coffee ____Cups/day Sleep ____Hours/day Exercise ____/Week

Drugs/Medication/Vitamins: _____

Please circle the symptoms you now have or have had recently.
Your health report is confidential and is treated as such by our staff.

Headaches Where _____	Shortness of breath Chest pain	Eye pain Deafness	Incontinence Painful urination
Dizziness	Arm pain	Ear pain	Frequent urination
Fainting	Fatigue	Hoarseness	Excessive thirst
Loss of balance	Rapid heart beat	Weight gain	Discolored urine
Weakness	Excessive sweating	Weight loss	Problems voiding
Slurred speech	Palpitations	Abdominal pain	Menstrual problem
Blurred vision	Poor circulation	Constipation	Alteration of:
Double vision	Swollen joints	Diarrhea	-skin temperature
ringing in ears	Wheezing	Belching gas	-skin color
Nausea/vomiting	Cough/phlegm	Stool changes	Enlarged glands
Numbness Where _____	Cough/blood	Rectal bleeding	Loss of memory
	Fever		

Please describe your pain and its location: _____

Frequency of episodes: _____

Prior treatment for present condition: _____

Prior studies (please circle): X-Rays MRI CT Sonogram Other: _____

Have you had any of the following (please circle):

CVA/Stroke	Heart murmur	AIDS/HIV	Arthritis:
Mental disorder	Colitis	Polio	Type: _____
Paralysis	Cirrhosis/Hepatitis	High blood pressure	Cancer:
Tremors	Herpes	Scoliosis	Type: _____
Epilepsy	Alcoholism	Hernia	Kidney stone
Thyroid problems	Drug addiction	Psoriasis	Rheumatic fever
Lung disease	Gall bladder disease	Anemia	Heart disease
Diverticulosis	Diabetes		Sexually transmitted disease

Please list any other serious medial conditions you have or have ever had:

Fracture (Area and date): _____ Surgery (Area and date): _____

Car Accidents (Date): _____ Serious Accidents (Date): _____

Hospitalizations (Date): _____

Are you presently being treated for any other condition? Yes No If so, by whom _____ for _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Patient's Signature: _____ **Date:** _____

FINANCIAL RESPONSIBILITY AGREEMENT

READ CAREFULLY

AS HEALTH CARE PROVIDERS IT IS IMPORTANT FOR US TO CLARIFY OUR STANDARD PROCEDURES FOR BILLING INSURANCE COMPANIES AND PATIENTS AT THE BEGINNING OF TREATMENT, SO THERE IS NO CONFUSION OR MISUNDERSTANDINGS. IF YOU DO NOT UNDERSTAND THE FOLLOWING PLEASE FEEL FREE TO DISCUSS WITH KELLY HUBER, D.C..

I understand that my insurance is an agreement between the insurance company and myself.

I, _____, take full **responsibility** for all bills incurred for treatment at Chiropractic Plus.

Chiropractic Plus will **assist** in billing your insurance carrier; however, the **responsibility of payment for services rests with the patient or the guarantor. THIS MEANS IF YOUR INSURANCE COMPANY DOES NOT PAY WITHIN 60 DAYS OR YOUR DEDUCTIBLE IS NOT MET YOU ARE REQUIRED TO MAKE PAYMENTS IMMEDIATELY- NO EXCEPTIONS.**

All charges are determined by the therapeutic procedures performed and the amount of time spent by the L.M.T. Be aware your treatment cost may vary because your insurance company determines the reasonable and customary charges based on the therapeutic procedures performed and the amount of time spent. The prescription letter of referral written by your physician determines what body areas and therapeutic procedures we perform.

For Group insurance patients our standard procedures and your responsibilities are to:

1. Group insurance companies do not guarantee payment when benefit information is requested; therefore it is your responsibility to pay for all bills you incur at Chiropractic Plus if your insurance company does not pay.
2. If your insurance does not cover your treatment at 100% **the balance will be billed to you.** (We accept check, cash, MC and Visa)
3. If your deductible is not met **immediate payment** for the patient is expected.
4. All payment arrangements need to be discussed before treatment is received with the Business Manager/ Kelly Huber, D.C.

I authorize payments to be made on my behalf directly to this provider for any service furnished to me by Chiropractic Plus. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services. I authorize Chiropractic Plus at any time I have an outstanding bill to be able to contact the insurance company for an exact dollar amount of benefits I have left. In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs. **Initial** _____

Consent for Care: It is my choice to receive chiropractic care with Chiropractic Plus. I am aware of the benefits of chiropractic care and give my consent to receive chiropractic care. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that therapy at Chiropractic Plus is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. **Initial** _____

Contract for Care:

I, _____, will participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based upon the information provided by Chiropractic +. I agree to participate in my own self-care program and adhere to the plan we select (for example: this includes ice and/or heat techniques, movement therapies/stretching and/or exercises, consumption of water, nutritional consideration and keeping scheduled appointments, etc.). I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide effective treatment to the best of his or her skill and knowledge. **Initial** _____

Signature: _____ **Date:** _____

A copy of this agreement will be as valid as the original.

I have read and understand all of the above information.

Dr. Kelly Huber | 135 Professional Dr. # 105 | Ponte Vedra Beach, FL 32082 | (904) 280-1101

Dr. Lee Nierman | 11512 Lake Mead Ave. # 203 | Jacksonville, FL 32256 | (904) 565-1116



CHIROPRACTIC PLUS

**AUTHORIZATION FOR TREATMENT
&
FINANCIAL AGREEMENT**

- I, the undersigned, understand that medical treatment is necessary and that such medical care; treatment and procedures will be performed by the physicians, therapist, and by employees of **Chiropractic Plus**. I hereby grant my authorization and consent to such treatment and procedure. Additionally, I understand that guarantees or assurance have been made as to the results which may be obtained.
- I, the undersigned, understand and agree to be financially responsible for all medical charges and services rendered, whether covered or not by my insurance. Additionally, I agree to pay any cost of collections including, but not limited to, attorneys fees, court cost and legal interest which may be incurred by **Chiropractic Plus**, while enforcing this obligation.
- In order to properly file your insurance claim we must have current copy of your insurance card and all personal information. We can not be responsible for correctly filing without accurate, current information.
- I, the undersigned, authorize, release of any and all medical information in connection with these services for insurance billing and collection purposes. I also authorize by my signatures, direct payment and assignment of all medical insurance benefits to **Chiropractic Plus**, as applicable, for professional medical and rehabilitative services rendered to me, and authorize submission of insurance forms and claims with the undersigned signature. This assignment may only be revoked with the express written consent of the medical provider.

I have read and fully understand the above agreements and acknowledgments.

Signature

Date

Printed Name

Dr. Kelly Huber | 135 Professional Dr. # 105 | Ponte Vedra Beach, FL 32082 | (904) 280-1101
Dr. Lee Nierman | 11512 Lake Mead Ave. # 203 | Jacksonville, FL 32256 | (904) 565-1116



CHIROPRACTICPLUS

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (Please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.