

# Application for Treatment

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer: \_\_\_\_\_ Social Sec # \_\_\_\_\_ On Disability?  No  Yes

Who referred you to this facility? \_\_\_\_\_

Who is your primary care physician / family doctor \_\_\_\_\_

Please describe the primary health problems for which you came to this office: \_\_\_\_\_

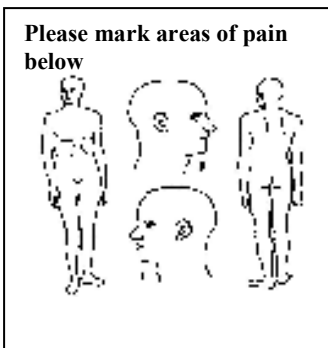
How and when did the symptoms first occur? \_\_\_\_\_

List any other doctors seen for this condition: \_\_\_\_\_

List diagnosis and type of treatment(s): \_\_\_\_\_

Have you lost any days of work?  No  Yes, List dates \_\_\_\_\_

Have you had similar symptoms or injuries before?  No  Yes, Explain \_\_\_\_\_



List in order of importance the conditions you are most interested in getting corrected:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What functions are you unable to perform or cause the most pain when trying to perform (ex: sitting, walking, bending, lifting, etc) \_\_\_\_\_

## PAST HISTORY

Have you been treated for any health condition in the past year?  No  Yes, Explain \_\_\_\_\_

List any surgical operations and years: \_\_\_\_\_

List medications you have used recently and their purpose: \_\_\_\_\_

Have you been involved in an auto accident within the past year?  No  Yes, When? \_\_\_\_\_

## FAMILY HISTORY

Name of Spouse: \_\_\_\_\_ Ages of children: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Your nearest Relative and Address: \_\_\_\_\_

List any relatives who have had similar problems: \_\_\_\_\_

## PAYMENT INFORMATION

How payment will be made:  Cash/Check  Credit Card  
 Bill Insurance: Your Deductible \_\_\_\_\_ Amount Met \_\_\_\_\_ Co-pay \_\_\_\_\_

Name of Company and Address: \_\_\_\_\_

**(Please allow the receptionist to make a copy of your card for billing purposes)**

Fees are payable at the time the examination and treatments are received unless other arrangements are made in advance. X-rays are the property of the clinic. I hereby give permission for treatment.

Print Patient/Guardian Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE**

Please mark any symptoms or conditions as listed below noting whether you have had it in the past or presently have. Correctly marking the conditions may influence treatment and outcome.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Low back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Mid back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the Upper Leg
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder/Stones
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Concussions	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke, date _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, location _____
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ringing in ears)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Chronic lung disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	Have you or your family had:		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	Yes	No	Relation
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain R or L	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, date _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Pain _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain/ Headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____

List any allergies you have: \_\_\_\_\_  
 Current Weight \_\_\_\_\_ Height \_\_\_\_\_ If female, ARE YOU PREGNANT No Yes

**WORK / SOCIAL HISTORY**

Work is primarily Heavy Moderate Light Sedentary  
 Exercise: \_\_\_\_\_ hours/week Type \_\_\_\_\_  
 Smoking: \_\_\_\_\_ packs/day for \_\_\_\_\_ years Alcohol: \_\_\_\_\_ drinks/week for \_\_\_\_\_ years  
 Caffeine: \_\_\_\_\_ cups/day (coffee / tea / cola) for \_\_\_\_\_ years Aspirin: \_\_\_\_\_ /day for \_\_\_\_\_ years

I certify that all the above information is complete and accurate to the best of my knowledge. I agree to notify this facility immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient/Guardian Signature _____	Date _____
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*Welcome to our clinic. Our doctors and staff work in partnership with our patients with a goal of coordinated care, medical excellence and high patient satisfaction. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery.*

**If you are here as the result of an auto or work accident, please notify the receptionist.** This coverage will typically cover most if not all of your treatment in this office. We may bill health insurance first to prove timely filing and default to health insurance as payment form if accident insurance does not pay.

We take your health very seriously and will make a 100% effort to give you the best possible healthcare. If you are unable to make your appointment please contact our office to reschedule as soon as possible. Patients who miss 2 successive appointments without calling to reschedule or reschedule 3 successive times may be released from care in order to make times available for other patients.

*Patients are encouraged to leave valuables at home or with an accompanying person. This facility shall not be liable for the loss of or damage to any personal property including money, credit cards, clothing, jewelry, documents or any other items.*

*Patients are able to schedule appointments during the posted clinical office hours. As a courtesy for you, we call you on the telephone to remind you of an upcoming appointment, when an appointment is missed and/or you have not been in for a while. This clinic may use a) a postcard mailed to you at home or work address or b) a call to your home, cell or work and leave a message on voicemail or with someone if your not available. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.*

*Your signature below fully authorizes our staff and doctors to perform any examinations, diagnostic tests and/or treatment as we may consider medically necessary and to release all information pertinent to your health, insurance or benefits to any and all applicable parties on your behalf. In addition you give our full consent and agreement to all terms and conditions regarding payment of account policies of this office as are explained here on the front and backside of this form.*

**INSURANCE BENEFITS – TERMS AND CONDITIONS**

- *Our providers and staff at Health Express, d.b.a. Health Coach (referred to in this document as “facility”), choose not to participate in most contracting insurance plans, thus while treating at this facility your insurance will be billed out-of-network in most cases. Our staff will try to verify your coverage and benefits for you and will discuss applicable benefits as they are told to us, but we can not guarantee the accuracy of what someone from your insurance company may tell us. Any insurance contractual obligations or arrangement between you and an attorney or third party payer are between you and your insurance carrier and/or third party payer.*
- *Our facility will file initial insurance claim along with any secondary claim submission and requested documents.*
- *Co-pays, deductibles and all non-covered service charges are due the day of service unless other arrangements are previously made.*
- *You are fully responsible for all costs of any services rendered you or your minor and such payment is not contingent on any settlement, claim, judgement, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full.*
- *Any balances past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court and filing fees. Returned checks, debit and credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30 charge. Please ask any questions you may have regarding your bill and/or fees to our billing department. We do not want any misunderstandings regarding your bill, obligation to pay or terms of when payment is due. For your convenience we accept most major credit cards.*
- *If at any time during the course of treatment you become financially unable to pay and/or the coinsurance or deductible becomes a hardship, the management may consider waiving a portion to assist you.*

*I have read and understand the above information as noted by my signature below.*

<p><i>Printed Name of Patient/Guardian</i> _____ <i>Date</i> _____</p> <p><i>Signature</i> _____</p>
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**INFORMED CONSENT**

*I understand this facility, its' doctors and staff will accept my case based on examination findings and believing that the treatment plan chosen should produce change and/or improvement. However, as with any examination, testing, or doctors care, a guarantee of improvement or complete recovery can not be made and it is possible that no change will occur. I further understand that in the practice of medicine, physical therapy and chiropractic, there are some risks including but not limited to fractures, strokes, disk injury, dislocations, sprains, strains, drug interactions and reactions and or other injuries or side effects which can not be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgement during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. Therefore, I give my full consent to the doctor/providers in this facility to render treatment on me, or the minor for whom I am legally responsible.*

*I acknowledge that I have read or had read to me and understand this form and agree to all terms and conditions. A photocopy of this document shall be considered as effective and valid as the original.*

**ASSIGNMENT – AUTHORIZATION AND LIEN**

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to this facility against any and all insurance benefits, proceeds of any settlement, judgement, or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the facility. I, the assignee further authorize any and all insurance company, attorney and any and all third party payer to pay directly to the facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health and accident, workers comp and including all insurance or third party benefits. Assignee agrees that this facility may deliver medical records, consultations, depositions and court appearance which must be paid in full in advance and authorizes this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee.

**DISCLOSURE OF FEE'S**

Health Express	
98940-52 Chiropractic Treatment (1-2 regions)	\$55
98941 Chiropractic Treatment (3-4 regions)	\$68
98943-59 Extra Spinal Treatment	\$46
99203 Intermediate Initial History & Exam	\$160
99204 Detailed Initial History & Exam	\$228
97140 Myofascial Release	\$49
97014 Electrical Stimulation	\$42
97012 Traction, Mechanical	\$39
97010 Hot/cold Packs	\$36
97035 Ultrasound	\$42
97110 Therapeutic Exercise	\$52
97112 Neuromuscular Re-education	\$47
97530 Therapeutic Activities	\$57

I have read the above codes and fee's and understand the cost of my care with this facility. I believe these codes to be reasonable and necessary. I understand that this is a general representation of the codes used in this facility and that other codes not listed may occasionally be used. I understand that I am responsibly for payment of all deductibles and co-payments related to my care. I understand that if I have a balance for medical services not paid, I will make a minimum payment of \$50 or 20% (auto-debit) of the outstanding balance each month, whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court, and attorney fee's in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the facility fee schedule regardless of the outcome of my case. If my insurance declines payment, I authorize this facility to file small claims on my behalf against my insurance company as a method of collection. I have read and fully understand the above information, financial terms and prices.

*I have read and understand the above information as noted by my signature below.*

<b>Printed Name of Patient/Guardian</b> _____	<b>Date</b> _____
<i>Signature</i> _____	