New Patient Information Form

Patient

First Name:_____ Last Name:_____ MI: _____

Mailing Address:_____Apt/Suite:_____ E-Mail: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Employer Name:_____ Job Title:_____

Business Address:_____ Business Phone: _____

DOB:_____ Age:_____ Gender: _____ SSN: _____ Marital Status: _____

Spouse or Guardian

First Name:_____ Last Name:_____ MI: _____ DOB:_____

Contact Phone Number:_____ Does your spouse have health insurance at work? _____

Emergency Contact

First and Last Name:_____

Phone Number:_____ Relationship: _____

Insurance

How will payment be made? Cash: ____ Check:____ Credit Card: ____ Care Credit: ____ Auto: ____ Work Comp: ____

Insurance Name: _____ Member #: _____

Group #:_____ Plan: _____ Insurance Policy Holder Name: _____

Name & Phone number of Primary Care Physician:_____

Do you have Medicare? _____ Do you have Medicaid? _____ Is your condition due to an accident? _____

By my signature below, I affirm the above information to be true and accurate. I also acknowledge my ultimate responsibility and liability for payment for any and all services rendered to me. I further affirm, in the case of any and all balance owing. I am responsible for any and all reasonable attorney and/or collection fees.

Signature:_____ Today's Date:_____

Printed Name: _____ Relationship to Patient:_____

421 South Tejon Street, Suite 120, Colorado Springs, CO 80903
Ph: 719-574-5500 / Fax: 719-476-4900

WARNER WELLNESS
CHIROPRACTIC

Chief Complaint Worksheet

Patient Name: Today's Date:
Symptom/Complaint:
Onset (**What** caused it & **When** did it begin?):
Provoke (What **Worsens** the complaint: position, activity, stress, food/drinks, motion, etc?):
Palliative (What makes it **better**: ice, over-the-counter meds, massage, position?):
Quality (Describe what you feel. Is it sharp/dull, burning/aching, and stabbing/shooting):
Radiation (Does the pain travel from one area to another?):
Reference: 0 being no pain, 10 is the worst pain you can imagine.
Severity: At its worst: 0 1 2 3 4 5 6 7 8 9 10 Percentage of time:
At its best: 0 1 2 3 4 5 6 7 8 9 10 Percentage of time:
Timing: Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?

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Office Policy

Our office is dedicated to 'getting you moving at the speed of life', through motivation, education, and example by offering efficient, cost effective and quality chiropractic health services to our patients, their families and their friends.

OUR RESPONSIBILITY: To fully evaluate, examine and diagnose your condition, which may require specialized diagnostic studies, such as x-ray, laboratory or consultation studies. We are very proud of our good reputation and will inform you if we cannot help your condition and/or make the appropriate referral to another health care professional who may.

YOUR RESPONSIBILITY: To complete all forms accurately and fully. To read and understand our policy, as well as all forms presented to you. To advise of immediately of any changes to your insurance benefit and coverages. ***Please feel free to ask us about any aspect of your visit today, which may be unclear to you.***

APPOINTMENTS: As a courtesy to us and all our other patients, please keep all your scheduled appointments in a timely manner. Rescheduling of appointments must be 24 hours in advance to avoid our ***missed appointment fee of $25.00 per visit.*** (We do understand extenuating circumstances!)

FINANCIAL POLICY: In keeping with our policy of efficiency and cost containment, we ask that all services, materials, and diagnostic studies be ***paid in full*** at the time of service or dispensary. We accept Cash, Check, Care Credit and most major Credit Cards.

INSURANCE/HMO/PPO/PAYMENT PLANS, ETC: Limited participation and/or assignment are available for ***automobile, worker's compensation, Medicare and many forms of third party reimbursement*****.** This does not alter your primary responsibility for COVERED AND/OR NON-COVERED BENEFITS and/or any treatment supply prescribed by our doctors. ***Please ask about our payment plans.***

I, THE UNDERSIGNED DO HEREBY AFFIRM THAT I HAVE READ AND UNDERSTOOD THE ABOVE POLICY AND DO HEREBY AGREE TO IT'S TERMS AND APPROVE OF THE EVALUATION AS DEEMED APPROPRIATE FOR MY REPORTED CONDITIONS, BY WARNER WELLNESS CHIROPRACTIC AND/OR IT'S AGENTS.

_____ _____

Full Legal Signature Printed Name

_____ _____

Witness Today's Date

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WARNER WELLNESS
CHIROPRACTIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I understand that I have certain rights to privacy regarding my protected health information. There rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent that I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g. my insurance company)
- The day –to-day healthcare operations of your practice.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient signature: _____ Date: _____

I DO NOT want to receive a copy of this document at this time. I understand that I may request a copy at a later date.

Patient signature: _____ Date: _____

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Patient Name:_____ Date:_____

DOB: _____ Address:_____

City:_____ State:_____ Zip:_____

CONSENT FOR TREATMENT

This document constitutes informed consent for examination, chiropractic care, supportive opinions and authorization to treat by Dr. Warner.

"Vertebral Subluxations" are interferences to the normal flow of brain impulses traveling over the nerve pathways. The method of corrections by introduction of gentle, specific force to the spine. These forces are intended to eliminate vertebral subluxations and align the spinal column. We do not offer to diagnose or treat any disease other than vertebral subluxations and spinal column imbalances. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatments prescribed by other.

By signing below, I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. As such, I will prepare and necessary forms for collection from the insurance company. Dr. Warner will assist me with reports and answer administrative questions: however, I am responsible for collection from my insurance carrier. I do authorize Dr. Warner to endorse and deposit directly to me and I am personally responsible for payment. Payment is not contingent on any settlement, claim, judgment or verdict. I also understand that payment for services are due and payable at the time of services unless prior arrangements have been made with Dr. Warner. If I suspend or terminate my care and treatment, any and all fees for professional services rendered will be due and payable.

I do hereby give permanent and irrevocable lien to Dr. Warner on any settlement, claim, judgment or verdict as a result of said accident/illness. I authorize my attorney/insurance carrier to pay directly to Dr. Warner such sums as may be due and owing for services rendered to me, and to withhold such sums from such sums as may be due owing for services rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Dr. Warner adequately.

I _____ have read and fully understand the above statements concerning exams, treatment and payment. All questions pertaining to my care in this office have been answered to my complete satisfaction

I, therefore, accept care on this basis_____

Signature Date

COMPLETE IF PATIENT IS A MINOR:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive health care.

_____

Parent/Guardian Signature Date Witness

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WARNER WELLNESS
CHIROPRACTIC

INSURANCE ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO PROVIDER

Date: _____

Insurance: _____

Address: _____

Patient Name: _____

Claim #: _____

Policy #: _____

Pursuant to C.R.S. 10-4-708.4, I hereby instruct and direct my insurance company to pay by check made out and mailed directly Warner Wellness Chiropractic. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make the check out to me and mail it to:

Warner Wellness Chiropractic
421 S. Tejon Street
Suite 120
Colorado Springs, CO 80903

You are instructed to pay directly to the doctor/therapist at the doctor's therapist' office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor/therapist. Also, I am personally liable for any unpaid accounts for hospital diagnostic and consultive services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment.

A photocopy of this assignment of benefits shall be considered as effective and valid as the original.

I also authorize Warner Wellness Chiropractic to release any information pertinent to my case to any insurance company, adjuster, and attorney, involved in this case, and hereby release the doctor of any consequence thereof.

_____ _____
Signature of Policy Holder Date

_____ _____
Signature of Patient (if other than policy holder) Date

Financial Policy

Welcome to our office! We are pleased that you have chosen Warner Wellness Chiropractic to provide your care and services. We would like to take a moment to inform you of our policies regarding payment with the office. We accept cash, personal check and credit card (Visa, MasterCard & Care Credit) for payment on your account.

Auto/Personal Injury Insurance (PIP, Med-Pay, 3rd Party, Lien): You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full. If we are required to send your account to collections, the balance due on that date will be doubled and interest at a rate of 1.5% per month will also be added to the balance due. ***If you have scheduled an appointment and do not cancel 24 hours prior to your appointment, you will be charged a $25 no show fee.***

Worker's Compensation: You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

Contracted /Private Insurance (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, an address to submit claims to, and a telephone number to allow us to verify coverage. You are still responsible for co-payment at the time of service, and any amounts not covered by your insurance, including deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for the entire balance due, based on our normal fee schedule. ***You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you re-schedule or sign a waiver for no referral or authorization thus holding you financially responsible.***

Medicare: We are ***NOT*** participating with the Medicare program at this time. We will be unable to submit your claims to Medicare. Please make other payment arrangements.

Cash Only Plan/No Insurance: Payment is due the day services are rendered by all patients on a cash only plan. Prompt payment is expected. Unless prior arrangements are made, overdue accounts will insure a 1.5% interest rate per month, plus reasonable collection fees.

I have read and understand the payment policies sent forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Warner Wellness Chiropractic.

_____ _____

Full Legal Signature Today's Date

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