Mahaska Chiropractic

218 North B Street
Oskaloosa, IA 52577
Phone: 641-673-8414

Patient Health History

Todays Date [/ /] Signature of Patient _____

Patient Title: *(check one)* ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr. ❒Prof. ❒Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Place of Employment _____

Mobile Phone _____

Home email _____ Work Phone _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method (check one)

❒ Primary Phone ❒ Secondary Phone ❒ Mobile Phone ❒ Home Email ❒ Work Email

Date of Birth [/ /] Age _____ Gender (check one) ❒ Male ❒ Female

Marital Status (check one) ❒ Single ❒ Married ❒ Other SSN _____

Employment Status (check one)

❒ Employed ❒ FT Student ❒ PT Student ❒ Other ❒ Retired ❒ Self Employed

Emergency Contact _____ Phone _____

Relationship _____ Referred by _____

What is your major complaint? _____

Female: Are you pregnant at this time? ❒ Yes ❒ No

Due Date: _____ LMP Date: _____

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan or arrange ment will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

2. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

3. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

4. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

5. If the patient is referred to another specialist of discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted.

6. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

MAHASKA CHIROPRACTIC
218 North B Street
Oskaloosa, IA 52577
(641) 673-8414

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Mahaska Chiropractic Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact Mahaska Chiropractic Clinic at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

►Patient Name (Please Print)_____

►Signature: _____

►Relationship to Patient: Parent Legal Guardian Other:_____

►Date: _____ Witness/Staff:_____

_____

I attempted to obtain the patient's signature, but was unable to do so as documented below:

Date: _____ Staff Initials: _____

Reason: _____

_____

_____