

Lucas Chiropractic Clinic

Patient Information

Today's Date ____/____/____ Date of Injury ____/____/____

Patient Name _____
LAST FIRST M SUFFIX

Current Mailing Address:

PO BOX OR STREET ADDRESS CITY STATE ZIP

Who **Referred** YOU to our Clinic? _____

<p>Contact Numbers:</p> <p>Home _____</p> <p>Work _____</p> <p>Cell _____</p>	<p>Date of Birth ____/____/____</p> <p>AGE _____</p> <p>S.S.N. ____ - ____ - ____ SEX - M F</p> <p>MARITAL STATUS - M S D W</p>
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What method of payment will you be using? Cash Insurance w/Co-Pay 100% Covered

INSURANCE?? PLEASE PROVIDE YOUR CURRENT INSURANCE CARD!!!

<p>Who is responsible for this bill?</p> <p>Name _____</p> <p>Address _____</p> <p>_____</p> <p>Phone _____</p> <p>Relationship to YOU? _____</p>	<p><u>Insured Information: IMPORTANT!!</u></p> <p>Name of Insured _____</p> <p>Date of Birth _____</p> <p>SSN of Insured ____ - ____ - ____</p> <p>Your Relationship to the Insured? _____</p>
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EMERGENCY CONTACT: Name _____ Phone _____

Office Use Only

Note:

Insurance Verification:

Health History

Date _____

Lucas Chiropractic Clinic
Bobby A. Lucas, D.C.
 1261 Seward Meridian #F
 Wasilla, Alaska 99654
 PH(907)357-6100 Fax(907)357-6102

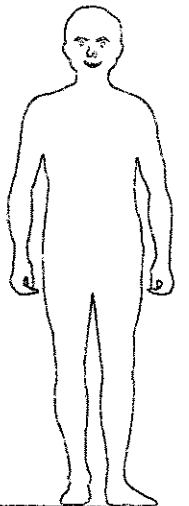
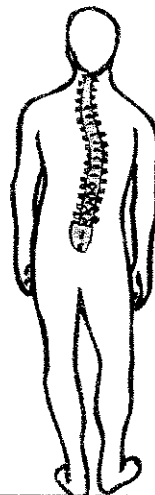
Patient Name _____

Purpose of Appointment <input type="checkbox"/> Consultation <input type="checkbox"/> Maintenance Care <input type="checkbox"/> Auto Accident <input type="checkbox"/> Worker's Comp. Claim <input type="checkbox"/> 2 nd Opinion <input type="checkbox"/> Change of Physician's	Your Main Complaint(s) _____ _____ _____ _____ _____ _____ _____ _____	When did you first notice symptoms? <input type="checkbox"/> Today <input type="checkbox"/> 1 week ago <input type="checkbox"/> At time of injury <input type="checkbox"/> Ongoing Problem <input type="checkbox"/> I don't know
		Ever treated for same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Major Surgeries? _____

Major Illness? _____

Mark an "X" on all that apply. →→→	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart Cond	<input type="checkbox"/> Polio	<input type="checkbox"/> Nervous	<input type="checkbox"/> Allergies
	<input type="checkbox"/> Backaches	<input type="checkbox"/> T.B.	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Rheumatic
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Sinus Trob.	<input type="checkbox"/> Other	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Digestive	<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV Pos.	

	<p align="center">Put an "X" on problem area (s)- Draw arrows.</p> <p align="center">Tingle Pain Shooting Pain Burning Numbness Heaviness Pinching Aching Stabbing Sensitive Tight or Tense Cramping Spasms Twitching</p>	

Have you been treated by a chiropractor previously? Yes No

Treating Physician's Name _____

Are you currently under the care of any other medical professionals right now?
 Yes No

What are you being treated for? _____

Patient Acknowledgement & Privacy Practices Approval Form
All Patients Must Review HIPAA Guidelines

Your Name _____

We like to offer each patient the opportunity to receive a birthday visit, referral visit and thank you card on our behalf. With HIPAA Privacy Practices we need your approval for the following communications with you.

Check the all box if you agree to receiving all items listed below:

- All Cards and Correspondence are approved
 - Birthday Card - for a free visit
- Referral Card - for each time you refer a patient you receive a free visit card.
 - Re-Call Card – Reminder to visit your chiropractor
 - Email Address – we may email you

May we address you by your first name in the lobby?

- Yes
- No

May we put your name on our referral board in the occasion that you refer another person to us?

- Yes
- No

All Patients Must Sign and Date the Below Form after reviewing HIPAA Privacy Practices given to you by the receptionist.

HIPAA Privacy Practices

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practiced with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (907)357-6100.

The Signature below is only acknowledgment that you have received this Notice of Our Privacy Practices.

Print Name _____

Signature _____

Today's Date _____

FINANCIAL POLICY – ALL PATIENTS MUST READ AND SIGN!!!!

____ Cash Patient: Payment is expected at the time of service. If you cannot pay on the day of service YOU will be billed the regular, no discount price.

____ Insurance Patient: We will gladly bill your insurance. YOU are responsible to pay your deductible at the start of your plan year, only after this, will the co-payment apply. You are responsible to pay your co-pay amount either at the time of service or before.

____ I authorize my benefit payments to be paid directly to Lucas Chiropractic Clinic.

____ I prefer to bill my insurance company.

Please READ & SIGN- I certify that the above information is true and correct. I understand and agree that health & accident insurance policies are an arrangement between my insurance carrier and myself. I understand that I am personally responsible for any non-covered products or services & if I discontinue my treatment, any fees for professional services provided to me, will be immediately due and paid appropriately. I have read and understood the above statement: Y N

Patient Signature: _____ Date _____