priebe CHIROPRACTIC

Patient Information

DR. RANDALL P. PRIEBE, D.C. | DR. JEFF J. PRIEBE, D.C. | DR. MATTHEW R. PRIEBE, D.C.

Patient Name : First Middle Last

Date of Birth : / / **SS#:**

Marital Status: Single Married Child **Sex:** Male Female

If child, guardian name **Cell Phone #:**

Email Address: **Emergency Contact:**

How do you prefer to be contacted? Email Phone **Emergency #:**

Mailing Address: City State Zip Code

Employer Name: **Occupation:** **Phone #:**

Employer Address: City State Zip Code

How did you hear about us?

Presenting Complaints or Symptoms

Medication/Drug Allergy

HEALTH INSURANCE

Insurance: Name Address City State Zip Code

Policy #: **Group #:** **Policy Holder:**

Policy Holder's Date of Birth: **Relationship to Patient:**

Although we bill your insurance company at your request, the insurance contract is between you and your insurance company. Ultimately, you are responsible for the payment for services received. Patients involved in litigation (lawsuits) are responsible for payment of services received unless other arrangements have been made with this office. This form serves as a medical record release, assignment of benefits, and Insurance Lien in the case of an accident or litigation. Please read carefully and sign below.

I fully understand that I am directly and fully responsible to said office for all medical bills submitted by him for service rendered me and that this agreement is solely for said office's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

I grant permission for above said office to exchange medical information with my referring physician, to the extent necessary to determine liability for payment and to reimbursement. I authorize disclosure of portion of the patient medical records to my insurance company.

I hereby assign all medical benefits for which I am entitled for services rendered to me or my dependent to be paid directly to above said office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I do hereby authorize above said office to furnish you, the insurance company, with a full report of his examination diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved, upon written request

I hereby authorize and direct you, the insurance company, to pay directly to said office such sums as may be due and owing him for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to myself, as the result of the injuries for which I have been treated in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my insurance company.

PATIENT SIGNATURE

DATE / /

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Patient Health Information

Please check mark each of the conditions below that you are currently experiencing

Musculo Skeletal System

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm Problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles, jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Gastro-Intestinal System

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty shallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems

Cardio-Vascular Respiratory

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

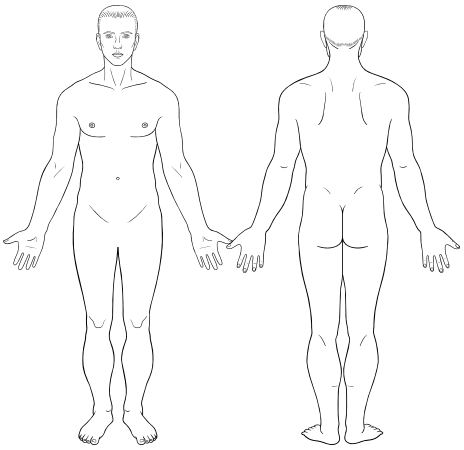
Eye, Ear, Nose & Throat

- ☐ Eye Strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear Pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ nose discharge
- ☐ Difficulty breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty speaking
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

Habits

- ☐ Cigarettes
- ☐ Alcohol use
- ☐ Coffee or Tea
- ☐ Drug use
- ☐ Exercise

Please mark areas of pain



PAIN INDEX

Least 1 2 3 4 5 6 7 8 9 10 Worst

Genito-Urinary System

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine
- ☐ Female vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on breast

Are you pregnant? ☐ Yes ☐ No

Have you ever had: ☐ Surgery ☐ Fractures ☐ Falls ☐ Car accidents ☐ On-the-job injury

Please Describe: _____

Family History: ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Heart Disease ☐ Back Problems

☐ Disc Problems ☐ High Blood Pressure ☐ Other:

Previous Serious Illness: _____

_____

Have you ever had chiropractic care? ☐ Yes ☐ No **How long ago?** _____

Have you been treated for any health condition by a physician within the last year? ☐ Yes ☐ No

If yes, please explain: _____

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DR. RANDALL P. PRIEBE, D.C. | DR. JEFF J. PRIEBE, D.C. | DR. MATTHEW R. PRIEBE, D.C.

8109 N. Wayne Blvd, Hayden, ID 83835 - Phone: (208) 667-7463 Fax: (208) 762-6385
850 Ironwood Dr. Suite 104, Coeur d'Alene, ID 83814 - Phone: (208) 664-5225 Fax: (208) 664 -5228

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND TREATMENTS, AND MASSAGE THERAPY

I hereby request and consent to the performance of chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me, (or on the patient named below, for whom I am legally responsible) by Priebe Chiropractic, Dr. Randall P. Priebe, Dr. Jeffrey J. Priebe or Dr. Matthew R. Priebe.

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

While the chances of experiencing complication are small, I understand and am informed that, as in the practice of medicine, in the practice of chiropractic care there are some risk to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the of the risks and complications and wish to rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts known is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below, agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment .

To be completed by Patient:

Patient Name (first, middle, last)

Signature of Patient

Date

If patient is a minor:

Name of Guardian

Signature of Guardian

Relationship to Patient

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name (first, middle, last)

Date of Birth

Signature

Date

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FINANCIAL STATEMENT

To our Patients,

Private Pay: Payment is expected at time of service. If this is not possible, we will be happy to discuss financial arrangements at time of service. A finance charge of 1.5% monthly may be charged to all balanced aged sixty days or older. By signing below, you acknowledge and agree to the above.

Insurance: Where no provider/insurance contracts apply, you are fully responsible for the balance due of today's services regardless of any contract that you may have with your insurance. A finance charge of 1.5% monthly may be charged to all balances aged sixty days or older. By signing below, you acknowledge and agree to the above, are authorizing release of medical or other information necessary to process this claim, assign insurance benefits to be paid directly to the provider, and authorize above office to submit claims to your insurance on your behalf.

Medicare: Payment of $40 is expected at the initial visit for a brief history and examination, unless prior arrangements have been made with this office.
Medicare will only pay for services that are deemed to be "reasonable and necessary" under section 1862(a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under Medicare program and standards, Medicare will deny payment for that service. Medicare may find that your spinal manipulation is not covered due to the diagnosis not supporting the frequency or length of treatments.
Medicare does not cover any exams, x-rays, therapies, or supplies. If the doctor feels that therapies/supplies are deemed necessary, we will be happy to discuss financial arrangements at the time of service. By signing below, you acknowledge and agree to the above.

Personal Injury (Auto Accident/Workers Comp): Although we will bill your insurance company at your request, the insurance contract is between you and your insurance carrier. Ultimately, you are responsible for payment of services rendered. Patients involved in litigation (lawsuits) are responsible for payment of services received, unless other arrangements have been made with this office. We recommend that a $25 payment be made monthly in order to keep your account active. If this is not done, our billing office will turn your account over to collections.
Please note for Auto accidents: In Idaho we are required to bill your insurance if you have Personal Injury Protection on your policy, even if the 3rd party is at fault.

Medicaid: Payment of $40 is expected at the initial visit for a brief history and examination, unless prior arrangement have been made with this office.
Medicaid will pay for 6 visits per calendar year.

***A $25.00 fee will be charged on all returned checks.**
***A $40.00 fee MAY be charged on No Show Massages, as our therapists are paid per massage.**
Please give 24 hour notice if possible; we understand emergency situations arise occasionally.

PATIENT SIGNATURE _____

DATE ____ / ____ / ____