

# Chiropractic Pain Relief Clinic

Please print clearly, if we are unable to read the information it will delay payment on your account

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ SS#: \_\_\_\_\_  
First Middle Last

Marital Status -Single -Married -Child Sex: -Male -Female Home Phone#:( ) \_\_\_\_\_ Cell#( ) \_\_\_\_\_

Email Address \_\_\_\_\_

(By providing your email address, we can provide you online access to your medical records, appointments, and reminders of future appointments.)

How do you prefer to be contacted: Phone \_\_\_\_\_ Email \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City State Zip Code

Physical Address: \_\_\_\_\_

City State Zip Code

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Address: \_\_\_\_\_

Employer Phone#: ( ) \_\_\_\_\_ City State Zip Code

If Child, Guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

How Did You Hear About Our Clinic? \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

Presenting Complaints or Symptoms: \_\_\_\_\_

Medication/Drug Allergy \_\_\_\_\_

### Health Insurance

Insurance: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_  
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 payment of 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, judgment 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 obtain reimbursement. I authorize disclosure of portions 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, judgment or verdict which may be paid to myself, as the result of the injuries for which I have been treated or injuries 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: \_\_\_\_\_

# Chiropractic Pain Relief Clinic 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

**Genito-Urinary System**

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

**Gastro-Intestinal System**

- Poor Appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody Stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

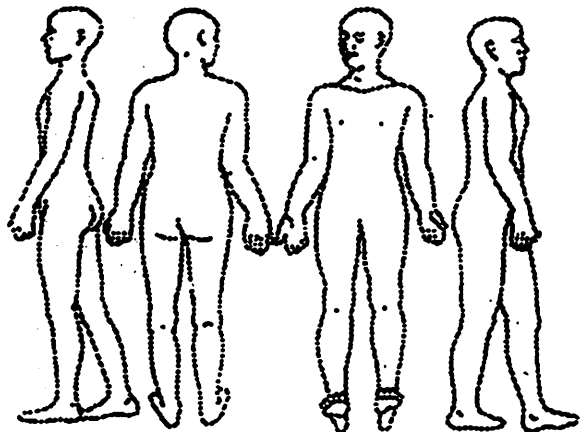
**Cardio-Vascular Respiratory**

- Chest Pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

**ARE YOU PREGNANT?**

- YES     NO

**SYMPTOM LOCALIZATION**



P \_\_\_ Pain  
N \_\_\_ Numb  
S \_\_\_ Spasm

T \_\_\_ Tender  
H \_\_\_ Hypoesthesia

**Nervous System**

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

**Habits**

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- \_\_\_\_\_

**Eye, Ear, Nose and Throat**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

**Pain Index**

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

Have you ever had:     surgery     fractures     car accidents     falls     on-the-job injury

Please describe: \_\_\_\_\_

Family History of:     Heart Disease     Cancer     Diabetes     Arthritis     Back Problems     High Blood Pressure  
 Disc Problems     Other: \_\_\_\_\_

Previous Serious Illness (Please list and describe): \_\_\_\_\_

Have you ever had chiropractic care?     Yes     No    Have you been treated for any health condition by a physician within the last year?  
 Yes     No    If yes, please explain: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_



**Randall P. Priebe, D.C.**  
**Jeffrey J. Priebe, D.C.**

8109 N. Wayne Dr. \* Hayden, ID 83835  
Phone (208) 667-7463 \* Fax (208) 763-6385

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**INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS  
AND TREATMENTS**

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 the Chiropractic Pain Relief Clinic, Dr. Randall P. Priebe or Dr. Jeffrey J. 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 of the risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts known is in my best interests.

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:**

**Complete if necessary:**

\_\_\_\_\_  
Print Patients (first, middle, Last) Name

\_\_\_\_\_  
Name of Guardian

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

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship to patient



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**Randall P. Priebe, D.C – Jeffrey J. Priebe, D. C.**

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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

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



**Chiropractic Pain Relief Clinic, P.A.**  
**Randall P. Priebe, D.C \* Jeff J. Priebe, D.C.**

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Phone (208) 664-5225 \* Fax (208) 664-5228

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## Financial Statement

### To Our Patients,

**Cash:** 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 balances 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 and 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 \$35.00 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 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/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 \$25.00 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 3<sup>rd</sup> party is at fault.

**Medicaid:** Payment of \$35.00 is expected at the initial visit for a brief history and examination, unless prior arrangements 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 \$35.00 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_