Flaskey Chiropractic &

317 6th Ave, Brookings, SD 57006

Whom may we thank for referring you?

□ Ad □ Internet
□ Phone Book □ Friend _____
□ Another Provider _____

Patient Information

Date: _____
Patient Name: _____ _____ _____
(First) (Middle) (Last)
Date of Birth:_____Age:_____
Sex: □ Male □ Female
Social Security Number: _____
Mailing Address:
_____
(Street Address or PO Box)
_____ _____ _____
(City) (State) (Zip)
E-mail Address: _____
Would you like to receive E-mail reminders? Yes / No
Phone Numbers: _____ _____ _____
(Home) (Work) (Cell)
Best time to reach you? _____
Would you like to receive text message reminders? Yes / No
If yes, who is your cellular provider? (Verizon, AT&T, etc) _____
Preferred Language:
□ English □ Other (please specify) _____
Race:
□ American Indian or Alaska Native □ Asian
□ Black or African-American □ White
□ Hispanic or Latino □ Multi-Race
□ Native Hawaiian or Pacific Islander □ Other Race
Employment:
□ Full-Time □ Part-Time □ Student
Employer/School: _____
Occupation:_____
Employer phone number: _____
Marital Status:
□ Married □ Widowed □ Single
□ Separated □ Divorced □ Minor
Number of Children: _____

In Case of an Emergency Contact:
Name: _____Phone Number:_____
Relationship: _____

Patient Condition

Reason for Visit:)_____
What caused your symptoms? _____
When did your symptoms appear? (date) _____
This condition is getting:
□ Worse □ Better □ Unchanging

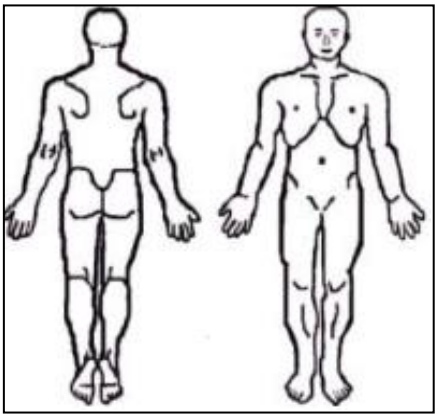
Type of Pain:
□ Aching □ Dull □ Shooting □ Throbbing
□ Burning □ Numbness □ Stiffness □ Tingling
□ Cramping □ Sharp □ Swelling □ Other _____

How often do you have this pain? _____

Does it interfere with your :
□ Work □ Sleep □ Daily Routine □ Recreation
Is there anything that makes the pain better? _____

Activities or movements that are painful to perform:
□ Sitting □ Standing □ Walking
□ Bending □ Lying Down □ Other _____

Circle/Mark on the picture where you have pain, numbness, or tingling.



No Pain <----------->Worst Pain
Mark an X on your degree of pain

Informed Consent

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications, while rare, may include: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, or burns. Fractures are extremely rare and generally result from some underlying weakness of the bone, usually stemming from a hidden disease process, which are check for during the taking of your history and during examination and x-ray, if clinically indicated. There are many wonderful benefits to chiropractic care, and remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. Other treatments available are self administered over the counter analgesics, rest, prescribed drugs, hospitalizations, or surgery.

I have read, or have had read to me the above explanation of chiropractic care and related treatment. I have discussed it with my doctor and have had my questions answered. Having been informed of any risks, I herby give my consent to treatment with Flaskey Chiropractic and Acupuncture.

_____

Patient signature (parent or guardian) Date Dr. Signature Date

Health History

What treatments have you already received for your condition?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other _____

Name and address of other doctor(s) who have treated you for your condition:

Approximate Date of Last
Physical Exam:_____ Blood Test:_____ Urine Test: _____ Dental X-Ray: _____
Spinal Exam: _____ Spinal X-ray: _____ Chest X-ray: _____ MRI or CT-Scan:_____
Bone Scan:_____

Female Only:
Are you pregnant? □Yes - Due Date: _____ □No Start date of last menstrual cycle: _____

Place an X on "Yes" or "No" to indicate if you or any of your blood-related family members have had any of the following:
Please identify any "Yes" answers as Self or a family member (mom, dad, brother, sister, grandma, grandpa).

AIDS/HIV	□ Yes □ No	Diabetes	□ Yes □ No	Liver Disease	□ Yes □ No	Rheum. Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Emphysema	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Epilepsy	□ Yes □ No	Migraine	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Fractures	□ Yes □ No	Miscarriage	□ Yes □ No	STD	□ Yes □ No
Anorexia	□ Yes □ No	Glaucoma	□ Yes □ No	Mononucleosis	□ Yes □ No	Stroke	□ Yes □ No
Appendicitis	□ Yes □ No	Goiter	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Arthritis	□ Yes □ No	Gonorrhea	□ Yes □ No	Mumps	□ Yes □ No	Thyroid Problem	□ Yes □ No
Asthma	□ Yes □ No	Gout	□ Yes □ No	Osteoporosis	□ Yes □ No	Tonsillitis	□ Yes □ No
Bleeding Disorder	□ Yes □ No	Heart Disease	□ Yes □ No	Pacemaker	□ Yes □ No	Tuberculosis	□ Yes □ No
Breast Lump	□ Yes □ No	Hepatitis	□ Yes □ No	Parkinson's	□ Yes □ No	Tumors / Growths	□ Yes □ No
Bronchitis	□ Yes □ No	Hernia	□ Yes □ No	Pinched Nerve	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bulimia	□ Yes □ No	Herniated Disc	□ Yes □ No	Pneumonia	□ Yes □ No	Ulcers	□ Yes □ No
Cancer	□ Yes □ No	Herpes	□ Yes □ No	Polio	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cataracts	□ Yes □ No	Hypertension	□ Yes □ No	Prostate Problem	□ Yes □ No	Whooping Cough	□ Yes □ No
Chem Depend	□ Yes □ No	High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	Other _____	□ Yes □ No
Chicken Pox	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No		

EXERCISE
□ None Type of exercises
□ Light _____
□ Moderate Times per week?
□ Heavy _____

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□ Never Smoked □ Current occasional smoker
□ Former Smoker □ Current every day smoker
□ Alcohol - Drinks/Week _____
□ Coffee/Caffeine Drinks: Cups/Day _____
□ High Stress Level - Reason _____

Injuries/Surgeries you have had: (please include the date)

Falls:_____ Head Injuries:_____
Broken Bones:_____ Dislocations: _____
Surgeries: _____ Other: _____

Medications:_____
Allergies: _____
Vitamins/Herbs/Minerals:

Privacy Policy Acknowledgement

I hereby acknowledge that I have been made aware that Flaskey Chiropractic, PC has a Privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**.

As a patient of Flaskey Chiropractic, PC, I understand and acknowledge that Flaskey Chiropractic has a privacy policy in their office and a complete version of the privacy policy is available for my review upon request. I am aware, that as a patient I am entitled to a copy of this privacy Policy.

Upon your review of the above statements, please sign and date at the bottom acknowledging that you have been advised of the privacy policy implemented by Flaskey Chiropractic, PC and have had the opportunity to read and understand the acknowledgement statement.

_____

Patient signature (parent or guardian) Date

Release of Information (limited to 1 year from signature date)

Please release my information related to : □ Billing □ Notes □ Other (please specify)
to the following person/group:_____ Signature: _____ Date: _____

Please release my information related to : □ Billing □ Notes □ Other (please specify)
to the following person/group:_____ Signature:_____ Date:_____

Please release my information related to : □ Billing □ Notes □ Other (please specify)
to the following person/group:_____ Signature:_____ Date:_____

Insurance Information

Who is the primary carrier/guarantor of the insurance? □ Self □ Parent/Guardian □ Spouse □ Other
Name of primary carrier/guarantor :_____
Relationship to patient:_____
Name of the insurance company(ies) specify primary and secondary:_____
Is this injury related to an accident? Yes No Date of Injury:_____
□ Auto Accident □ Worker's Compensation □ Other (please explain) _____
Please explain what happened: _____
_____
_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named company (ies) and assign directly to Flaskey Chiropractic, PC all insurance, Worker's Compensation and/or Automobile Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Flaskey Chiropractic, PC may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents, third party payer, or attorney for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Patient signature (parent or guardian) Date

Financial Responsibility and Policy for Flaskey Chiropractic, PC

Effective December 6, 2016

Understanding Your Insurance Policy & Our Billing Policy

• Insurance companies usually take a minimum of 1-2 months to process claims from the date of service, sometimes substantially longer.
• Once we receive a statement from your insurance company, we then calculate your portion based on what your insurance tells us you are responsible for and send out billing statements. We typically do not send out an invoice until your claims have processed through your insurance, so this is why you will see a time gap between the service and your billing statement.
• Deductable, coinsurances, and uncovered amounts are determined by your insurance company to be your responsibility. (*please contact your insurance company for a list of your benefits if you are unsure.)
• Acupuncture – Unfortunately, acupuncture is most often not covered by insurance. There is a $30 charge on the date of service for acupuncture. (*please contact your insurance company for a list of your benefits if you are unsure.)
• MEDICARE – Medicare does not cover a New Patient Exam or any type of therapy such as acupuncture, electrical stimulation, or ultrasound. Flaskey Chiropractic, PC will collect for these charges on the date the service is provided. Medicare also does not cover "maintenance care". If Medicare determines that your service is considered maintenance, you will be responsible for the services provided on that date of service.
• We reserve the right to charge $30 for all missed appointments without a 24 hour notice.
• If we have not received payment in full, or arrangements in writing (agreement form will be provided) by the second monthly billing cycle, after insurance processing, your account will be referred to collections. If a payment is missed after an arrangement has been made between yourself and Flaskey Chiropractic, PC, we will not make an attempt to contact you again. Your account will automatically be referred to collections.
• The payment options we have available are cash, check, money orders, and credit/debit cards.
• We reserve the right to charge a $40 service charge for all returned checks.
• We require a minimum of a $30 payment from all patients prior to treatment with the following exceptions: Worker's Compensation and Personal Injury cases, as well as with insurance policies with a specified copay.

_____

Patient signature (parent or guardian) Date