Allied Healthcare, PLLC

Patient Information

Name:_____ **Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Birthday:_____ **Sex: (Check)** ◯**M** ◯**F** **Social Security Number:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Email Address:_____

Work:_____ **Work Address:**_____

Occupation:_____ **Hobbies:**_____

Emergency Contact:_____ **Phone:**_____

Marital Status: (Circle) ◯**Single** ◯**Married** ◯**Divorced** ◯**Widowed**

Person Responsible for the bill:

Responsible Party Name:_____ **Responsible Party Birthday:**_____

Insurance Company:_____ **Insurance ID:**_____

Who referred you to our office? How did you hear about us? _____

Who is your Primary Care Provider? _____

Are you pregnant? (Circle) ◯**YES** ◯**NO** **If so, CONGRATS!! Please list DUE DATE:**_____

Current Condition:

Your present complaint/describe your symptoms:_____

Is your visit due to an automobile accident or work-related injury: (Circle) ◯**YES** ◯**NO** **Date of accident:**_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Does anything make it feel better? _____

Does anything make it feels worse? _____

Has this condition: (Check one) ◯ **Improved** ◯ **Unchanged** ◯ **Getting Worse**

Is this condition interfering with your: ◯ **Work** ◯ **Sleep** ◯ **Daily Routine**

Other:_____

Have there been other Doctors/Therapists who have treated this condition:

_____

What do you think caused this condition? _____

Have you had an X-Ray, CT Scan, or an MRI in the past 28 days? _____NO _____YES

(If so, when and where?) _____

Health History:

Exercise:		**Work Activity:**		**Habits:**
_____None	**_____Moderate**	**_____Sitting**	**_____Standing**	**_____Smoking-packs/day_____**
_____Daily	**_____Heavy**	**_____Light or**	**_____Heavy Labor**	**_____Alcohol-drinks/week_____**
				_____ Caffeine- cups/day_____

Personal Health History:

Cancer (Prostate/Colon/Breast):_____ **High Blood Pressure:**_____
Diabetes:_____ **Stroke:**_____ **Coronary Vessel Disease:**_____ **Heart Disease:**_____

Immediate Family Health History:

Cancer (Prostate/Colon/Breast):_____ **High Blood Pressure:**_____
Diabetes:_____ **Stroke:**_____ **Coronary Vessel Disease:**_____ **Heart Disease:**_____

List medications currently taking- including dosage: If none, check here_____

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

Which Pharmacy do you use? _____

List any known allergies you have had to any medications. If there are none, check here _____

1._____ **2.**_____ **3.**_____

List surgical operations and the year performed:

_____
_____

Printed Name:_____

SIGNATURE:_____ **DATE:**_____

Parent/Guardian SIGNATURE:_____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain the risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and sprain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that the best of my knowledge, I am not pregnant, nor is this pregnancy suspected or confirmed at this time. Date of last menstrual cycle:_____

Patient Name (printed): _____

Patient Signature:_____

Relationship or authority if not signed by Patient:_____

Witness:_____ Date:_____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $300 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.**
2. **If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance must not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.**

You are considered a cash patient until you bring in your complete insurance information, and we will qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept the responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. You further agree to pay as a collection fee of 33% of the principal amount to reimburse Allied Healthcare its collection costs if my account is assigned to a collection agency.

Personal Injury Cases: If an account balance is not paid in FULL within six (6) months of the first date of service, the patient will be required to begin making minimum monthly payments toward the account balance regardless of settlement/claim status.

If you discontinue care for any reason other than discharge by the doctoral balances will become immediately due and payable in full by you, regardless of any claim submitted.

We bill insurance carriers as a courtesy to our patients, it is not required by law for us to do so. It is ultimately the patients responsibility to contact your insurance carrier to determine what services may or may not be covered. It is also your responsibility to contact your insurance company regarding any questions of payment and/or denials of treatment.

Date:_____

Patients Printed Name:_____

Patient Signature or Legal Guardian:_____

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received or asked for a copy of Allied Healthcare, PLLC's notice of Privacy Practices for protected health information.

Date:_____

Name of Patient (printed):_____

Signature of Patient/Personal Representative:_____